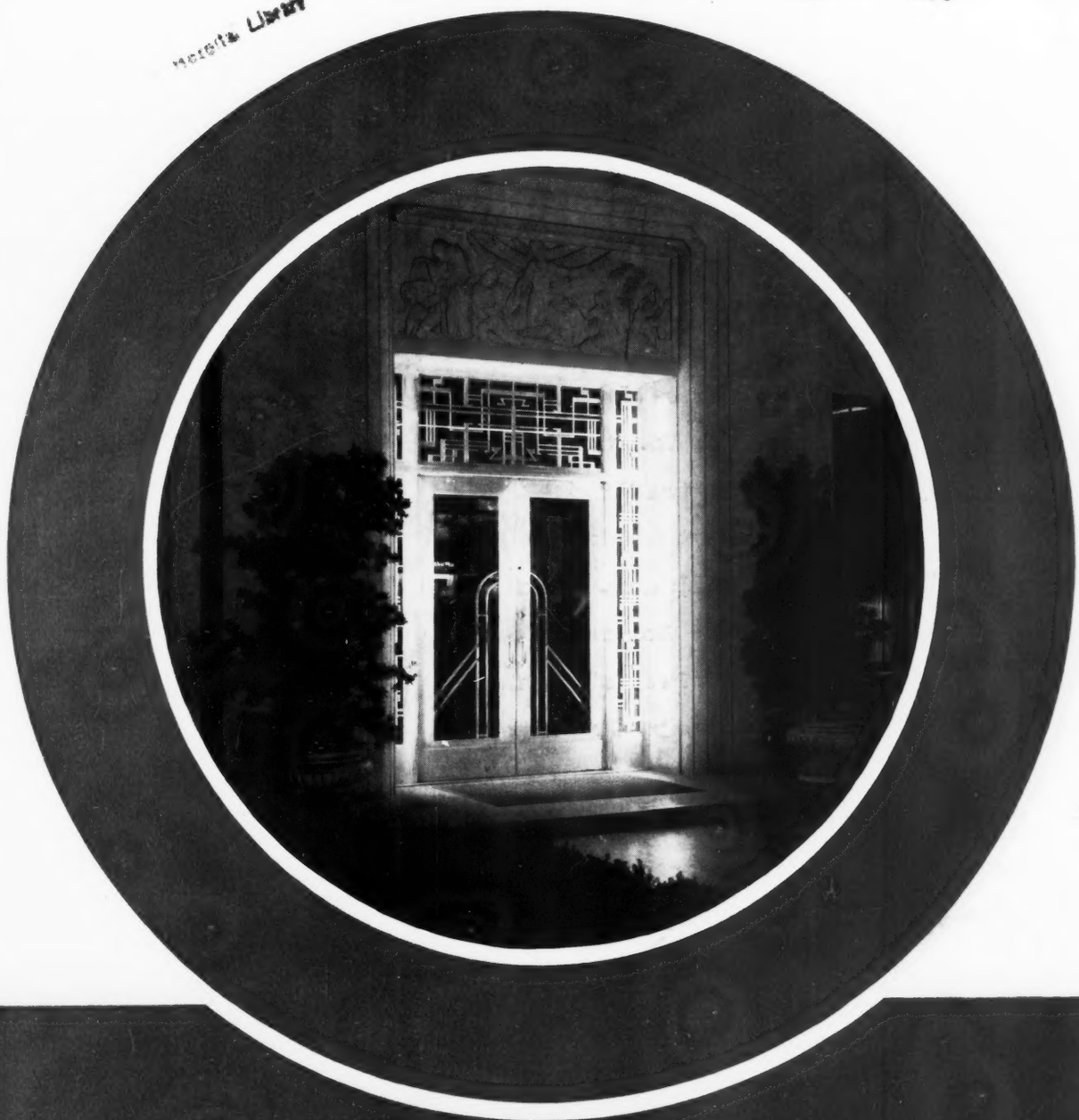

the MODERN HOSPITAL

VOLUME 51 DECEMBER 1938 NUMBER 6

"Unless a tree has borne blossoms in the spring, you will vainly look for fruit in the autumn."

—THEODORE ROOSEVELT,
25th President of the United States

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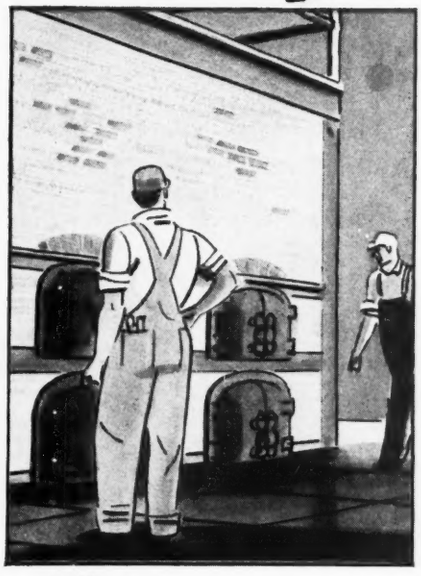

*Here

In the laundry alone, savings up to 50% on soap, washing compounds and detergents—savings of 25 to 30% on linen replacements! That's the kind of savings scores of Permutit-equipped hospitals report. Reason: Hardness in water wastes soap, turns it into a sticky, grayish soap scum. This makes fabrics dingy and gray, makes threads stiff and brittle, shortens their life. Permutit stops it!

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WITH THE ROVING REPORTER

Christmas Plans

Looks like a busy Christmas season in hospitals everywhere! Hardly an administrator visited by your Roving Reporter who has not something to report about Christmas plans—parties for the nurses, trees with presents for the children, greetings and holiday cheer for everyone. None will be forgotten, if early preparations mean anything.

One idea seems just too good to keep. Let's see if everyone agrees. It should be explained that this particular hospital has become public relations conscious during the past year. All sorts of outside groups have been invited for meetings at which tea, coffee and light refreshments were served. There have been dinners, too, and luncheons. Naturally, this has added to the burdens of the employes, particularly those in the dietary department.

So it was decided that kitchen workers, the entire mechanical staff in fact, be given a party all their own. A committee appointed by the ladies' auxiliary is in charge of the arrangements, which include a Christmas tree on which there will be hung stockings filled with candy for every man and woman. Each stocking is to bear a card with the name of the individual and a few words of thanks for the part he or she has played in making friends for the hospital during the year. It is to be signed by the president, on behalf of the entire board.

A few more ideas such as this and there need be little concern about labor trouble.

Gifts for All

Then there is another plan that seems particularly promising. This is for the smaller hospital where the family spirit prevails. Everyone exchanges presents—presents limited to a very modest sum — with precisely whom they don't know.

Here is how it is done. Each employe is given a slip on which is the name of some other employe to whom he is to give a gift. But the recipient never knows the name of the giver.

Around the Christmas tree, bright with tinsel and lights, the gaily decorated parcels are stacked. And there is a Santa Claus, who proceeds to call out the names and enliven the proceedings with merry quips. Usually one of the doctors officiates. Surely such a party can't fail.

Hospital Spirit

So much for Christmas spirit, and who isn't the better for it? Now, what about hospital spirit in general, the everyday variety that meets its true test on blue Monday mornings when an unusually large number of operations are posted and everyone is frantic, or on other occasions, when some emergency must be faced? And when is there not some emergency?

No one is more sensitive than the patient—the visitor, too, for that matter —to harmony and a spirit of accord existing between members of the staff and the hospital personnel. It doesn't take long to detect their presence or absence.

Some time ago, we described the radio broadcasts at St. Mary's Hospital in Pierre, S. D., by which relatives and friends are kept advised of the patient's condition.

At that time, George Kienholz, our informant, had something to say, too, about this important matter of hospital service. Here it is fresh from your Roving Reporter's notebook.

"A spirit of cooperation on the part of all individuals who contact the patient during his hospital stay reflects itself in the impression the visitor or the patient retains as he returns home. I have had people say, and mean it, 'If I had not had this operation, I would not have met the doctors and nurses and I would not have missed knowing them for the world.'

"The hospital personnel and staff members should radiate happiness. I believe the time is past when because we are dealing with sick people, we should be expected to weep with them. Sympathetic, yes, by all means, but always a happy disposition and surroundings conducive to causing the sick to forget their troubles. To put color into the walls and the furnishings, a little on the cheeks of the patient, causing visitors to say: 'How fine you look,' isn't entirely out of place, either.

"I admit that a certain amount of professional dignity may be necessary— we still like to hang on to old traditions —but the world as a whole is not as quiet and reserved as it used to be in the traditional times. Why, then, should the haven of the sick not change with the changing times? Help to make the transition of the patient from home to hospital bring as little shock as possible. In fact, everyone knows of instances in which the patient puts forth every possible excuse to keep from being discharged and sent home."

Have You a Baby Album?

You've all heard a lot about prize baby contests. Those who have experimented can speak from experience. It's generally a hectic one, too, with literally dozens of wailing youngsters and exhausted, anxious mothers sitting about waiting for the final verdict. Well, if Mount Sinai Hospital in Philadelphia didn't decide to stage a baby contest—without the babies! By proxy, you might say, or to be more explicit, by camera shots, the more candid, the better.

They named the contest "A Picture of Health." A specified time was given in which the photographs could be submitted. All that parents were asked was to send in their favorite photograph of baby, instead of baby himself.

Now let's see how it worked. If the entry appeared to be in top form, a questionnaire was sent out asking for specific information regarding illnesses, physical defects and the like. Replies and pictures were then matched for a second rating, following which the final contenders were requested to come to the hospital for a thorough physical examination. There was just one prize winner, who received $10.

Entries who reached the finals were invited to a gala party in their honor. In addition to members of the medical staff who assisted, a well-known portrait artist of Philadelphia served as one of the judges. The hospital offered to return all pictures so marked but expressed the hope that it might be permitted to keep them permanently to form a Baby Club Album.

"Let us see what baby looks like today, showing off a new tooth perhaps. Let us know how big she's grown, no longer a baby, but a pert little missy. Let us share in the joy of seeing the rough and tumble school boy we knew as a tiny tot."

Even before the allotted time had elapsed, 200 pictures were received. So when next in Philadelphia, be sure to stop in at Mount Sinai and ask to see the Baby Club Album. Some babies!

LOOKING FORWARD

International Congress, 1939

APPARENTLY the Toronto meeting of the International Hospital Association next September will rank as the best ever held by the association in its endeavors to coordinate and advance hospital work in all countries. Dr. Malcolm T. MacEachern, president of the International Hospital Association, and Dr. G. Harvey Agnew, president of the American Hospital Association and also host to the convention, are working in close cooperation to make sure that the basic material of the program represents the best hospital thought of the world.

Careful attention also is being given to all details of the five day meeting. All papers and reports on various aspects of hospital organization and management are to be printed in five languages and interpreters will be present at each session so that every visiting hospital delegate will be able to make himself understood and to understand others. If peace is preserved in Europe, undoubtedly a large attendance will come from abroad.

Study tours have been arranged en route from Montreal to Toronto and from Toronto to New York City by way of Niagara Falls and Chicago, as well as to other parts of the United States and Canada. Immediately following the International Congress, the annual meetings of the Protestant Hospital Association, the American College of Hospital Administrators and the American Hospital Association will convene in Toronto.

Naturally a meeting such as the congress involves considerable expense. Unfortunately the threat of impending war and resulting unsettled conditions in Europe curtailed the income of the I. H. A. from that source. But the United States, also, has not met its quota of support. Now that the I. H. A. has progressed so favorably and a great congress has been planned for America next year, is it not fitting that the United States should assume its full share of financial support of this organization?

The quota for the United States is $1300. A total of $300 has already been paid, including an appropriation from the American Hospital Association. Membership in the I. H. A. is offered to individual hospital administrators and trustees at an annual cost of only $5. While nonmembers will be freely admitted to the Toronto sessions, they will not, of course, be accorded the privileges that of necessity belong to members. Setting a good precedent among organized hospital groups, the Pennsylvania Hospital Association and the Tri-State Hospital Assembly have taken association memberships in the I. H. A. Other state and regional associations might well emulate their example.

The question may be asked, "How can an association, a hospital or an administrator benefit from membership in the I. H. A.?" The answer can be found in perusing the objectives and accomplishments of the association. Its aims are: (1) to provide a means for free interchange of thought among the hospitals of the world; (2) to obtain a knowledge of hospital systems the world over; (3) to permit more comprehensive study of hospital problems; (4) to assist the hospital executive when traveling in foreign countries, and (5) to promote a world-wide unity among hospitals.

These aims are accomplished through: (1) the collection of literature, reports, plans and other information; (2) the publication of the journal, *Nosokomeion;* (3) the holding of a biennial congress; (4) the promotion of study tours; (5) the appointment of international study committees on hospital problems and the publication of their work, and (6) the promotion of national hospital units.

It is hoped that the association will attract many new members in the near future. Its cause is sound and its need is great.

Health Centers and Hospitals

THE pressure for an increase in the number of health centers is mounting in New York City and in Chicago, as well as in other places. The health center is a useful device for bringing the activities of the health department into the neighborhood where it can be of most value. But the health center should be confined to its proper function.

The committee on public health relations of the New York Academy of Medicine has made careful study of this subject and has laid down the following as the proper functions of the health department: (1) control of communicable diseases, (2) enforcement of the sanitary code, (3) public health education, (4) keeping of

morbidity and epidemiologic records and collection of demographic data, (5) health conservation service and (6) maintenance of diagnostic, analytical and research laboratories and the manufacture of biologic products required for battling communicable diseases.

But the proponents of health centers wish to go beyond this list. "The establishment of treatment clinics unconnected with hospitals is contrary to sound medical and administrative policy," the committee says in reply. "This applies with especial force to prenatal clinics, eye and cardiac clinics and, in some measure, to independent tuberculosis clinics, syphilis clinics and gonorrhea clinics. As far as possible, gonorrhea should be treated in hospital clinics where facilities for consultation with competent genito-urinary experts, gynecologists, internists and other specialists are available, and where patients may be hospitalized for the application of the newer and more effective methods of treatment which can be applied only in hospitals." The committee evidently feels that the argument for incorporating the other types of clinics in hospitals is too self-evident to need mention.

It is no derogation whatsoever of the health department to suggest that it eliminate treatment activities. As the committee points out: "It is in the preventive aspect of medicine, which is often neglected in hospital and dispensary work, that the health department has a real responsibility. This responsibility should be exercised by an active supervision of all hospital clinics, both public and voluntary, dealing with communicable disease, so as to ensure proper attention to the necessary details of a preventive program. This health department function should take precedence over the setting up of duplicate treatment facilities."

This question, of course, is two-sided. While hospital work necessarily has a preventive aspect, hospitals must not attempt to take over from public health authorities preventive medicine in the full sense of the term. Also hospitals must be prepared to offer a well-rounded clinic service if they are to preserve their rightful claim to this activity.

Doctor Goldwater expressed the idea aptly in his address to the American College of Hospital Administrators at Dallas. "For the encroachment of public health administration on therapeutic territory," he said, "the excuse is offered that hospitals are not fulfilling their function. The criticism is not without foundation. We as administrators must try to make our job of personal medical care a complete job. We must see to it that our service to the sick is properly implemented by a comprehensive program, satisfying all the reasonable demands of modern medical practice. There must be no gaps in clinical coordination, in laboratory service, in diagnostic aids, in convalescent care, in follow-up work, in medical social service, in the protection of the health of hospital workers. There must be close cooperation with public health departments and with voluntary social and health agencies."

If hospital clinics are inadequate in number, location or service, let us concentrate attention on remedying these defects instead of trying to fill gaps with overlapping organizations and with "unattached" clinics.

Limitations of Blood Banks

A FEW months ago the blood bank idea completely captured the public interest. To the average man or woman the deposit in and withdrawal of blood from an orderly arranged storage box was at once a new and attractive idea. The tabloid press was quick to dramatize the idea and some hospitals and physicians were quite willing to join in the publicity campaign.

Now that the furor is past, the blood bank principle is capable of proper evaluation. The speed with which blood can be supplied in an emergency is an undoubted advantage and often has saved lives. Neither the school of direct nor of indirect transfusions can deny this. There is little, if any, danger in the practice of storing blood under proper conditions for at least a week or ten days. Many hospitals store blood for a much longer time. In the presence of infection blood that has been removed from the circulatory system for more than a few hours probably loses its antibody content and, hence, its therapeutic value. Some laboratory technicians separate serum from blood cells and administer each to meet different treatment needs.

The blood bank possesses a definite administrative value. It substitutes deliberation and careful attention to detail for haste and confusion, which often accompany the preparation of a donor and a recipient for a blood transfusion. Hence, it should obviate mistakes in typing and cross-agglutination which have, to be sure, rarely happened. Furthermore, it should prevent the administration of the blood of persons who show a positive serologic reaction.

The blood bank is not a therapeutic or administrative cure-all. It is, when properly developed and administered, a splendid addition to the efficiency of the hospital's practical procedures.

Maximum Purchasing Power

EACH dollar of the hospital budget should purchase the greatest and most effective number of hours of hospital care for the sick. Any circumstance that shortens or weakens this service is detrimental to the welfare of the community. These statements are self-evident.

But what are the things that may uselessly consume a part of this dollar? These are a few: a large mortgage or current debt the interest on which prevents the use of the whole dollar, inefficiency in administration, a listless or indifferent staff and absence of proper

laboratory and other specialty services. These and many other defects make it impossible for the patient to purchase hospital care thriftily. When incomes lag medical care becomes less efficient. As a result, through no fault of the hospital, the purchasing power of the patient's dollar decreases.

By pooling resources several institutions may render a better and more effective service than could be the case when acting separately. One large laundry can be operated more economically than several smaller ones. When community surveys recommend a combination of hospital resources, those institutions concerned should seriously, even prayerfully, consider the proposition before rejecting it.

Selected Raw Material

FOR generations the fallacy of endeavoring to make a whistle out of a pig's tail has been a family byword. Freely interpreted as applied to the education of doctors, nurses and other professional persons, it is not so much the school, faculty or curriculum that counts as it is the human raw material with which it works.

Specifically, a hospital school is successful in educating good nurses only if it properly selects those whom it admits as probationers. Social backgrounds and early family rearing play a much greater rôle in developing a good nurse with all that this term implies than do correct laboratory tables and good teachers.

Loose social, ethical and moral thinking can only be expected if a young woman has lived in such an intellectual atmosphere for almost two decades. Bad personal hygiene, ignorance of social usages or crude table etiquette cannot be corrected by a course of lectures, no matter how eloquent the instructor. Moreover, even three years' exposure to ways of living designed to correct these personal defects is likely merely to dent the veneer with which modern youth unconsciously has concealed her deeper hereditary or environmental traits.

The day of selection of the members of a nursing class is of far greater importance to the hospitals and to the community than is the gala time of graduation.

The Spirit of Charity

THE civilized world recoils from the use of the word "charity" in designating the work of social agencies which have been created and are being maintained in the good old-fashioned spirit of mutual aid. The true humanitarian takes language into consideration in planning for his humble neighbor. We now speak of welfare work, philanthropy, social service, neighborhood work and a few other things dressed in modern style, to spare the sensibilities of our underprivileged fellows.

The change in terminology is coeval with the change from "consumptive" to "tuberculous," from "home for incurables" to "hospital for chronic disease," and from "cancer clinic" to "tumor clinic" or "radiotherapy clinic." This is all to the good and demonstrates, in a measure, how far we have progressed along the humanitarian way.

Charity is, however, charity by whatever name it may be called. We do not increase the measure of our kindness or of our sympathy for the poor unless we do more than change the name. The man who is charitable in the performance of his duties is the one who spares the sensibilities of his client (if he has any left after confiding in the social worker). The action must suit the word, in any case.

A name that has startling and unhappy connotations should not be changed for one that is milder and more soothing, unless the change is accompanied by recognition in a practical way of the true value of mutual aid, even when it masquerades under a less condescending name.

Welfare work, philanthropy, social service and neighborhood work, which will some day be recognized along with other human rights and privileges, may be all right as far as they go, but they do not go far enough if the charitable motive is obscured in any way.

Legal Literature for Hospitals

ONE of the specialized and involved fields of hospital administration is that of the law in its relation to hospital patients and others. Yet this is among the last to be clearly explained or standardized. A short study of the available hospital legal literature brings one to the realization that not only is there no standardized national literature for hospitals on this subject, but no literature has been developed by the individual states.

Despite the fact that hospitals in their daily activities meet the law at nearly every turn, surprisingly little has been done to chart this sea of administration. It would be impossible to cover in a single volume the laws affecting hospitals in all the states, as the law in its interpretation varies in every jurisdiction.

However, there is one course open, that is, to have every state develop its own literature. An attorney who is especially interested in hospital work might be persuaded to write such a volume covering the rulings of each state. If the American Hospital Association would sponsor such a plan, hospital administrators would have a guide which would be invaluable to them. The recent book, "Legal Aspects of Hospital Practices," written by two New York attorneys, covers mainly New York law and would be an excellent inspiration and model for similar books in other states.

Such legal literature not only would serve the day-to-day needs of hospitals but would be helpful in framing legislation in various states and in promoting hospital procedures in accordance with approved legal practices.

Placental Blood Transfusions

TRANSFUSIONS with placental blood have been used in St. Mary's Hospital, Montreal, for the last two years, during which time more than 300 transfusions with fetal blood have been given. Blood has been shipped on several occasions to other hospitals in Montreal where facilities for this work do not exist.

In all this time there have been but two physical reactions, one a mild urticaria, and the other a severe accession of fever in a septic case, both of short duration without untoward sequelae. One other case, a staff physician's wife, had a severe chill of a purely nervous type without fever or physical change. This is the sum of unexpected after effects.

The physiologic effects are similar to those of ordinary transfusions, differing only in degree. The greatest advantage of the fetal blood bank lies in its preoperative activation of the reactive system of the body and in cases of toxic hemorrhage of whatever kind.

This source of blood was first discovered by the authors, who attempted to disprove that a placenta that is rigid with blood will detach itself more readily than a placenta that is emptied. Accordingly, the cord was allowed to fall down over the vulvar towel and the cord clamp was released. The blood often spurted 3 feet under its pressure and gravity and continued to bleed for quite a while. Then suddenly the thought occurred, why not save this blood for transfusion purposes? Immediately means were found to put the idea into operation.

The best preservative was found to be that of the Moscow Institute of Hematology, which consists of the following ingredients:

Sodium chloride	7.0	gm.
Sodium citrate	5.0	gm.
Potassium chloride	0.2	gm.
Magnesium sulfate	0.004	gm.
Bi-distilled water	1000.0	cc.

The preservative is put up in ampules of 25 cc. capacity and of such strength that when added to 100 cc. of distilled water the dilution corresponds to the foregoing formula. It would seem advisable for small institutions to use the ampules but larger institutions may have the preparation made by any qualified chemist.

A temperature between 34° and 38° F. has been found to be the optimum. A refrigerator in size proportionate to the size of the institution must be obtained. A clock thermometer connected by a wire coil with the interior of the blood chamber stands upon the top of the refrigeration plant so that the temperature can be ascertained at all times without opening the plant.

Installed, the St. Mary's equipment cost less than $250. Its cost would be considerably less in the United States. The inner capacity of the refrigerator is approximately 3 by 2.6 by 1.8 feet, suitable for a general hospital with a bed capacity of 240. A correspondingly larger unit will be required for larger hospitals.

Checking Amounts on Hand

The different blood groups are kept on different shelves so that the amount of each may be seen at a glance. Opening the refrigerator door at frequent intervals, though it changes the temperature of the chamber temporarily, does not appreciably alter the temperature of the blood. About three dozen Erlenmeyer flasks of 300 cc. capacity are found to be the safest for this work; and one dozen funnels of 3 inch diameter, with a stem that reaches down one-half the depth of the flask. Plugs of gauze filled with cotton serve as stoppers and loose cellophane caps are used to cover the tops and short necks of the flasks. Two dozen pipettes, 12 to 15 inches long, also are needed. One dozen small test tubes with corks are required for the collection of blood both for Wassermann testing and grouping.

All glassware must be boiled and thoroughly rinsed with several changes of distilled water. Next, 125 cc. of the preservative fluid (or the contents of one ampule to which 100 cc. of distilled water is added) is decanted into the Erlenmeyer flask and the cotton stopper and cap are adjusted. The flask is then wrapped in a cotton wrapper in such a way that releasing the pin or string at the top allows the towel to fall down freely about the hand supporting the flask from below. The funnel is similarly wrapped so that when held by the top by the nurse, the stem is easily exposed. Flasks are then sterilized in the operating room autoclave. As many as desired may be so prepared and kept. They keep indefinitely. The pipettes are wrapped or kept in a glass tubular container and similarly sterilized.

Uses Table for Collecting

A small table is set apart in the case room for collecting blood. On it are one wrapped Erlenmeyer flask with its preservative, one funnel, a bottle of 70 per cent alcohol, a small sterile wrapped tray containing swabs, sterile scissors and a towel with an aperture 2 by 3 inches in its center. On the table also are small labeled test tubes. Half of these are filled half full with sterile normal saline solution for purposes of grouping. The table is wheeled near the patient when blood is to be collected. As soon as the baby is born it is placed upon the mother's abdomen and the cord is ligated immediately. The cord is then held at the point of ligation by the index finger and thumb of the right hand, as the doctor stands between the patient's thighs. With the index finger and thumb of the left hand armed with a sponge, the cord is stripped free of blood for about 4 inches from the ligature. With the right hand, which is free, this depleted segment of the cord is wiped clean with a sponge moistened with alcohol and is severed with the sterile scissors.

The left hand, still holding the severed end of the cord, is lowered between the patient's thighs so as to obtain the maximum of gravity. With the right hand the perforated

towel is placed over the left arm so that the aperture is opposite the finger and thumb of the left hand, which still holds the severed end of the cord, and the towel is held *in situ* by an Allis forceps applied to its upper margin, making it fast to the operator's sleeve.

The nurse, during the foregoing steps by the *accoucheur,* releases the collecting flask from its covering, removes the plug with a sterile forceps, places it upon the tray and proceeds to disengage the stem of the funnel from its covering by holding the funnel in the left hand at the margin of the rim. She places it in the neck of the collecting flask. She lowers the flask held in her left hand so that the end of the cord is within the upper rim of the funnel and the doctor releases the pressure on the cord. It takes about three minutes to collect the blood. It is stirred or agitated as little as is possible.

The flask is placed upon the table and the nurse collects in each of two small labeled tubes (one half-filled with saline solution) a few drops of blood for grouping and a tube half-full for a Wassermann. The doctor replaces the plug in the flask and the main container is labeled with adhesive, on which are the patient's name and the date of her delivery, in black ink. The sample for grouping is examined as soon as convenient and the group is indicated on the flask in large red lettering. The Wassermann is indicated by a red minus sign below.

Tests for Public Cases

The Wassermann is done on public cases during the last two months of their antepartum treatment and is not repeated with the fetal blood unless so desired. In private cases the fetal blood is tested upon collection. The flask of blood and container are transferred within a reasonable time to the refrigerator.

When transfusion is required the blood group of the recipient is first obtained. A flask of fetal blood of the corresponding group, or group 4, is chosen. A sterile pipette plugged with absorbent and stoppered with the finger is lowered into the flask to the layer of blood cells. The finger is then released and replaced and the captured cells are gently withdrawn. Matching, by the major reaction, is now done by the fetal cells against the recipient's serum.

Refrigerator for storing blood. Note clock thermometer on top.

As many fetal bloods are treated in this way as are required for the transfusion. When the bloods are found to be compatible, the flasks are gently swirled to mix the component elements of the blood and are placed in a water bath at about 105° F. while the patient is being prepared. All transfusions are given by gravity, as in an ordinary intravenous saline, and the blood is always filtered through two layers of gauze. Bloods should not be pooled before or during transfusion. But one fetal blood may follow another through the gravity chamber without interruption. Saline solution may or may not be added at any time.

If the recipient belongs, let us say, to group 2 and there happens to be a shortage of fetal blood of that group and one wishes to supplement by one or more of group 4, then the bloods corresponding to that of the recipient should in all cases precede the administration of the group 4 blood. Since group 4 blood is usually different from that of the recipient, unless she happens to be of that group, it has a tendency to cause temporary incompatibilities in the recipient. Hence the foregoing rule.

Fetal blood has quite distinctive characteristics. Its cellular content averages about seven million to the five million of the adult; it contains from 25 to 35 per cent more thrombotic power; it is rich in humoral extracts, and it contains many immature nucleated red blood cells having a high degree of fragility.

When fetal blood is collected and preserved, it sediments into three layers, the lowest composed of red blood cells. Closely applied to this is the white cell layer, differing markedly in thickness in different specimens. Upon these layers is the supernatant fluid composed of plasma and preservative. The last named may differ markedly in appearance in different specimens. In most it is a clear amber colored fluid, which, as days or weeks elapse or if it is disturbed, becomes pink tinged from the deeper parts. In others, it is decidedly turbid from the beginning, owing to the presence of substances of unknown composition.

When the baby is pink and well oxygenated at birth, the blood is of a bright red color. When the fetus has a high degree of anoxemia, the collected blood is very dark, at times almost black, and does not preserve as well as the red type, because it hemolyzes more rapidly and never regains its normal color during preservation. This is no hindrance to its use in transfusion. It improves markedly in color when filtered through the gauze at the time of transfusion.

There have been quite a number of cases in which a small or large cushion or hump lay on the surface of the red cells after sedimentation. This hump is covered by a layer of white cells. To ascertain its nature presented a problem. Microscopi-

cally it was a tenacious homogeneous mass, sterile to culture. It was eventually found to be caused by cord jelly that had gotten into the blood during collection. It has no untoward effect during transfusion.

Cultures have been frequently taken but have always proved negative. It is assumed that, should a slight contamination take place at the time of collection, it would have no serious consequences, because blood kept at so low a temperature would inhibit any multiplication and the contamination would be so attenuated and so diluted as to be innocuous. Moreover, the awakening of the body reaction of the recipient by the transfusion would be a masterly preventive.

Owing to the freedom from infection in St. Mary's bloodwork, positive blood cultures should warrant strict investigation of case room technic in general.

Hemolysis Is No Barrier

Considerable degrees of hemolysis are no barrier to the use of such blood for transfusion purposes. This breaking down has been proved to be purely mechanical in character and chiefly caused by the greater fragility of the immature nucleated cells. The test of whether or not a hemolyzed blood should be used for transmission is found in the intactness of the red cells withdrawn for matching purposes at the time of an intended transfusion.

The advantages of fetal and preserved blood over the adult type lie both in the original properties of the collected blood and in its preservative properties. Preserved blood has fewer allergic reactions than fresh blood, owing to the breaking down of the unsplit proteins. It is available at all times and much time is saved in cases of emergency.

Preserved fetal blood not only has the advantages mentioned but it is richer in thrombin, therefore of greater advantage in hemorrhagic cases and, being young blood, is extremely active in awakening the reticulo-cellular activity of the body as a preventive and as an aid to combat infection. It can, and has been, preserved for four months and has been used at the end of that period with good effect.

Its greatest advantage is found in its use as a preoperative measure. In cases in which there is no grave anemia, as evidenced by an hemoglobin estimate, or, better still, by a complete hemogram, the infusion of the blood collected from one placenta only is sufficient to immunize the patient preoperatively.

It has reduced the risks of economic hazards in semiprivate cases in which surgical judgment dictates that a transfusion would greatly increase the chances of an uninterrupted recovery but financial hazards compel an opposite decision.

The Wassermann reaction upon the fetal blood of private patients who had not been previously so examined has revealed an unexpected positive reaction in certain instances, which was confirmed by the immediate examination of the parents' blood. Appropriate treatment was then possible at a much earlier date than would have been otherwise.

As fetal blood costs almost nothing, it has been possible to reduce the price of a full transfusion to $10 for private patients, $7.50 or $5 for semiprivate and $2 or nothing for public cases. The staff of the surgical or gynecologic pathologic department takes care of the blood and of its grouping and matching, without any increase of personnel or cost. Thus, it has been possible to defray all the expenses of the research laboratory and leave a rich surplus of income.

Blood has been shipped to other hospitals with the greatest facility. If the destination happens to be in the same city, transmission by taxi without refrigeration is sufficient. If extra-urban, it should be packed in a vacuum pail and carefully labeled.

Extrahospital cases, or cases from a great distance, can easily be grouped and matched by the following simple method. Take a piece of white filter paper, roll it into the form of a cigaret and insert it into the test tube containing the recipient's blood so that it just reaches the surface of the blood. It will suck up the serum and, when a small segment is saturated, it can be withdrawn and dried on a radiator and sent in an envelope to the blood bank. Here, a small piece, 2 by 2 cm., is inserted into a test tube and moistened with normal saline solution so that, when macerated, there is a small amount of supernatant fluid. This is withdrawn with a pipette and, except for a slight paper flocculation, gives a perfect medium for matching and grouping.

There are certain conditions that become axiomatic as regards mother, child and accidents of labor. Fetal blood should be collected only from full-term or nearly full-term cases. It should not be collected from patients whose membranes have been ruptured for more than forty-eight hours and, obviously, it should not be collected from any mother suffering from communicable disease. Preeclampsia or eclampsia is not a contraindication, however.

In cases of prematurity and of asphyxia pallida the amount of blood obtainable is negligible. On the other hand, where, owing to neck coils, the cord has to be severed before complete birth, the amount is inordinately large.

Supply Adequate for Needs

The maternity section of a general hospital, if proportionate to the other departments, can supply a sufficiency of blood to meet all the average present day requirements of that institution, but it may not meet all the requirements of the near future. It is now the generally accepted belief of those in a position to know that, in the near future, blood transfusions will be almost completely substituted for intravenous salines, except in very special cases.

It is our belief that the preservatives now in use are inadequate and that the next refinement will permit blood to be kept indefinitely in a condition of suspended animation. The life of working red and white blood cells is variously estimated at from 30 to 90 days, but no one knows the life history of blood held in a state in which its vitality is reduced to a condition of quasi-quiescence. This is our present day study.

It will take a great deal of work. First problems are to determine: (1) a uniformity of circumstance; (2) a minimum of cell food, assimilable under these circumstances, and (3) an atmosphere that is acceptable.

Under present circumstances placental blood preservation has proved a safe, constant, efficient, time saving source of supply for transfusion.

Insurance for Indigents

ALDEN B. MILLS

THE success already achieved by hospital care insurance plans and the prospects for extending these plans in cooperation with authorized medical organizations to include physicians' service are indeed heartening. It has been conservatively predicted that the present type of hospital plan providing semiprivate service will be protecting a total of 10,000,000 persons by the end of 1942. If ward service plans that include physicians' care are developed on a low cost basis, they may soon serve another 10,000,000 persons or more.

What relation should be developed in the next five or ten years between these plans for the self-supporting and the plans now being evolved for the indigent and near indigent? The National Health Program recommends that the federal government aid the states and localities in setting up complete medical service for this one-third of our population.

Shall two separate, parallel and competing systems be set up in this country or shall there be one coordinated and integrated plan? Shall we have a Grade A service for two-thirds of the population and a Grade B service for the balance?

Six Reasons for Plan

Let us examine some of the arguments in favor of a unified hospital and medical service for all.

1. A unified system would provide the same freedom of choice of physician and hospital to the indigent or near indigent person as he has when he is self-supporting.

2. It would avoid duplicating administrative expense.

3. It would assure that the quality of service given to the indigent and near indigent would be as good as that provided to full pay subscribers. The hospitals and doctors need not know, in fact, whether a particular patient is paying his own bill or is fully or partly subsidized by governmental agencies.

4. It would preserve continuity of relationship between the patient and his physician and hospital. He could receive service from the same physician and hospital this year when he is working as he did last year when he was on relief.

5. It would preserve professional control over professional problems and relieve governmental agencies from the responsibility of attempting to direct hospitals and physicians in detail concerning their service. Governmental agencies could agree on general policies which the hospitals and physicians would themselves enforce.

6. A voluntary nonprofit professionally directed insurance organization could represent hospitals and physicians more effectively than they could be represented on an individual basis. It would have approximately equal bargaining power with governmental agencies. This would prevent undue exploitation of hospitals and doctors.

There are certain practical difficulties. First, what would become of existing general hospitals owned and operated by cities, counties and states? In England, the "contributory schemes" pay for service to their members in such hospitals. A similar plan could well be used here. Moreover, a larger proportion of these facilities might be used for chronics.

Second, where would teaching institutions obtain patients for teaching purposes? There are two possible answers: one, that teaching is now done successfully in many places on paying patients, and the other, that no system of this kind will include absolutely everybody.

Third, governmental agencies might feel that the plan would not give them sufficient financial control. True, the plan could only work if the expense to the government is kept at the lowest possible point consistent with quality, efficiency and soundness. But could any governmental agency, without exploiting doctors and hospitals, set up a separate plan to care for, say 50,000 indigent and near indigent persons, at any lower administrative cost than they could be cared for through a well-managed voluntary organization which is already caring for 75,000 or 100,000 persons? Within certain limitations, unit administrative expenses decrease as size increases.

Obviously, the final cost to government should be no greater than government would have to pay to render service of similar scope and quality to the same number of patients through its own facilities. Actually, the cost should be less. Governmental agencies probably would have to pay only part of the expense for the near indigent, who at present usually receive free care.

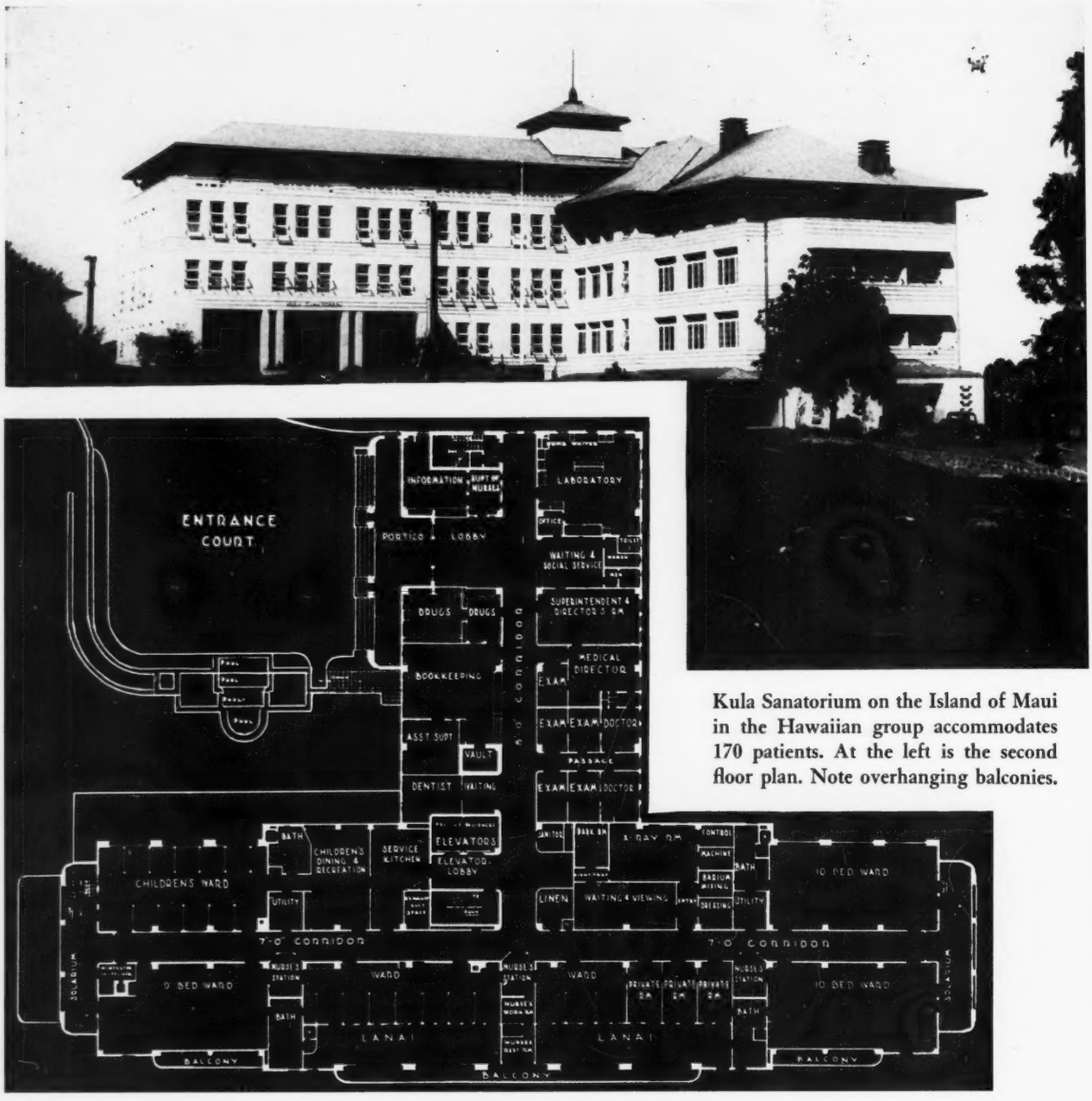
Utilizing Group Practice

A fourth possible objection might be that a governmental agency can utilize group practice and thus achieve economies not obtained in individual practice. But there is no reason to assume that group practice, if desirable, cannot also be achieved by voluntary action.

There are other practical difficulties, of course. But that this proposal is not entirely visionary is indicated by the fact that in North Dakota a plan already is operating which combines health insurance for the self-supporting with subsidized service for the indigent. While the North Dakota plan is under governmental auspices and therefore not comparable to the present proposal, it indicates that the basic idea of a unified service has already found favor. For care of the near indigent, Louis Reed of the Social Security Board has tentatively recommended the same idea.

A unified, coordinated medical service for all people is in keeping with American democratic traditions. If the practical difficulties can be overcome, America would indeed have a medical service worthy of its resources and its opportunity.

Maui's Tuberculosis Sanatorium



Kula Sanatorium on the Island of Maui in the Hawaiian group accommodates 170 patients. At the left is the second floor plan. Note overhanging balconies.

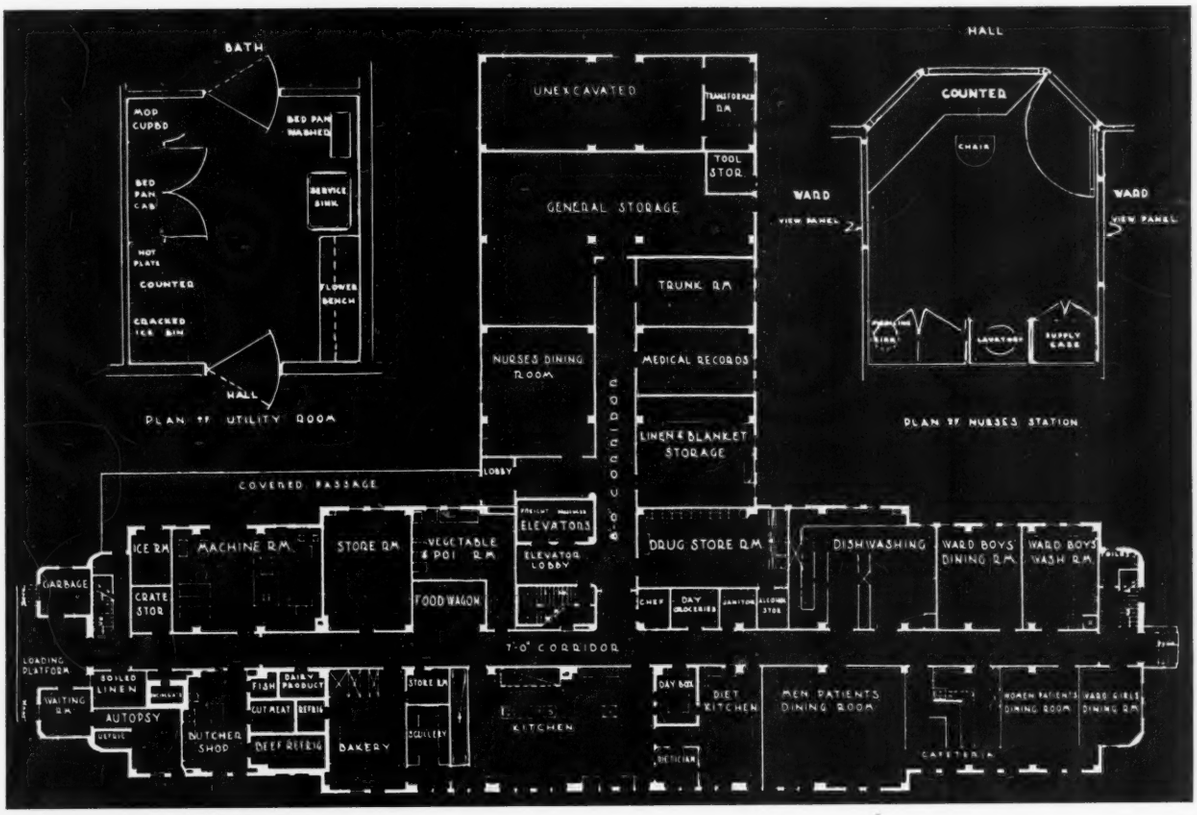
By C. W. DICKEY

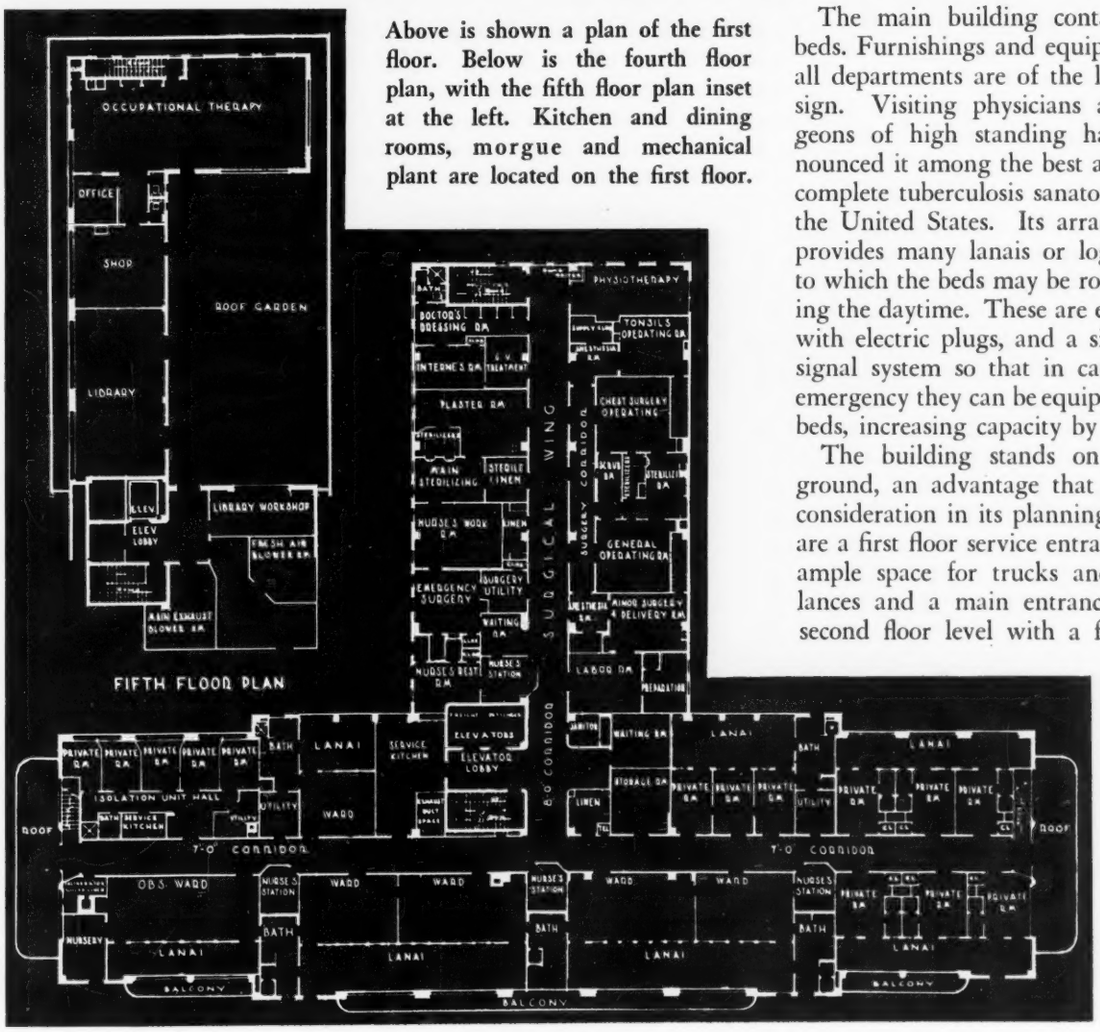
KULA Sanatorium, on the Island of Maui in the Hawaiian group, is a tuberculosis hospital located 25 miles from the nearest town and 3500 feet above sea level on the slopes of Mount Haleakala. It is a building such as one might expect to find in a large city but hardly in such a remote location.

The explanation lies in the fact that about 25 years ago, when climate was considered of paramount importance in the treatment of tuberculosis, the Kula Sanatorium was started with a few tents. The dry cool air and high altitude were considered ideal for the treatment and the results obtained confirmed this belief.

The institution grew rapidly until today a half million dollar fireproof, modern and well-equipped hospital has replaced the original tents. It is reached by excellent roads and is supplied with fresh mountain water from the Kula pipe line and with electricity from the power plant of the electric company at Wailuku. The hospital has 367 acres of land, including its own dairy, piggery, poultry farms and vegetable gardens. It does its own butchering and operates its own laundry.

In addition to the main hospital there are a preventorium, a nurses' house, three doctors' cottages, a superintendent's cottage, the help's quarters, an amusement hall, shops, a laundry and a small general hospital for the district.





Above is shown a plan of the first floor. Below is the fourth floor plan, with the fifth floor plan inset at the left. Kitchen and dining rooms, morgue and mechanical plant are located on the first floor.

The main building contains 170 beds. Furnishings and equipment in all departments are of the latest design. Visiting physicians and surgeons of high standing have pronounced it among the best and most complete tuberculosis sanatoriums in the United States. Its arrangement provides many lanais or loggias on to which the beds may be rolled during the daytime. These are equipped with electric plugs, and a silent call signal system so that in case of an emergency they can be equipped with beds, increasing capacity by 61 beds.

The building stands on sloping ground, an advantage that received consideration in its planning. There are a first floor service entrance with ample space for trucks and ambulances and a main entrance at the second floor level with a forecourt.

On the first floor are located the kitchen department, mechanical plant, storage, morgue and necropsy room. There is a large loading platform near which are located the garbage room and crate storage room as well as an incinerator and soiled linen room, both served by chutes from the upper floors. Next comes the machine room with boiler plant, gas plant, refrigeration machines and ice room.

On the opposite side of the hall is the butcher shop with a cold storage room for beef carcasses, which are brought in suspended from an overhead trolley, a refrigerator for cut meats and poultry and one for fish. Next comes a well-equipped bakery with cold storage box and a large storeroom opposite. Then come the scullery on one side of the hall and, opposite, a vegetable room and alcove for food wagons. Next to the scullery is the large kitchen with two electric ranges, a broiler, a steam roaster and four steam kettles. There are a steam table, cook's table, space for tray carts, work tables and sinks.

Adjoining the kitchen are a refrigerating day box, dietitian's office and diet kitchen. All trays are made up in the main kitchen and distributed from there. Next to the kitchens comes a cafeteria with dining rooms for men patients, women patients, ward girls and ward boys. Across the hall is a dishwashing room with two steam dishwashers, sinks and silver burnisher. On this floor there also is a nurses' dining room with special service arrangements.

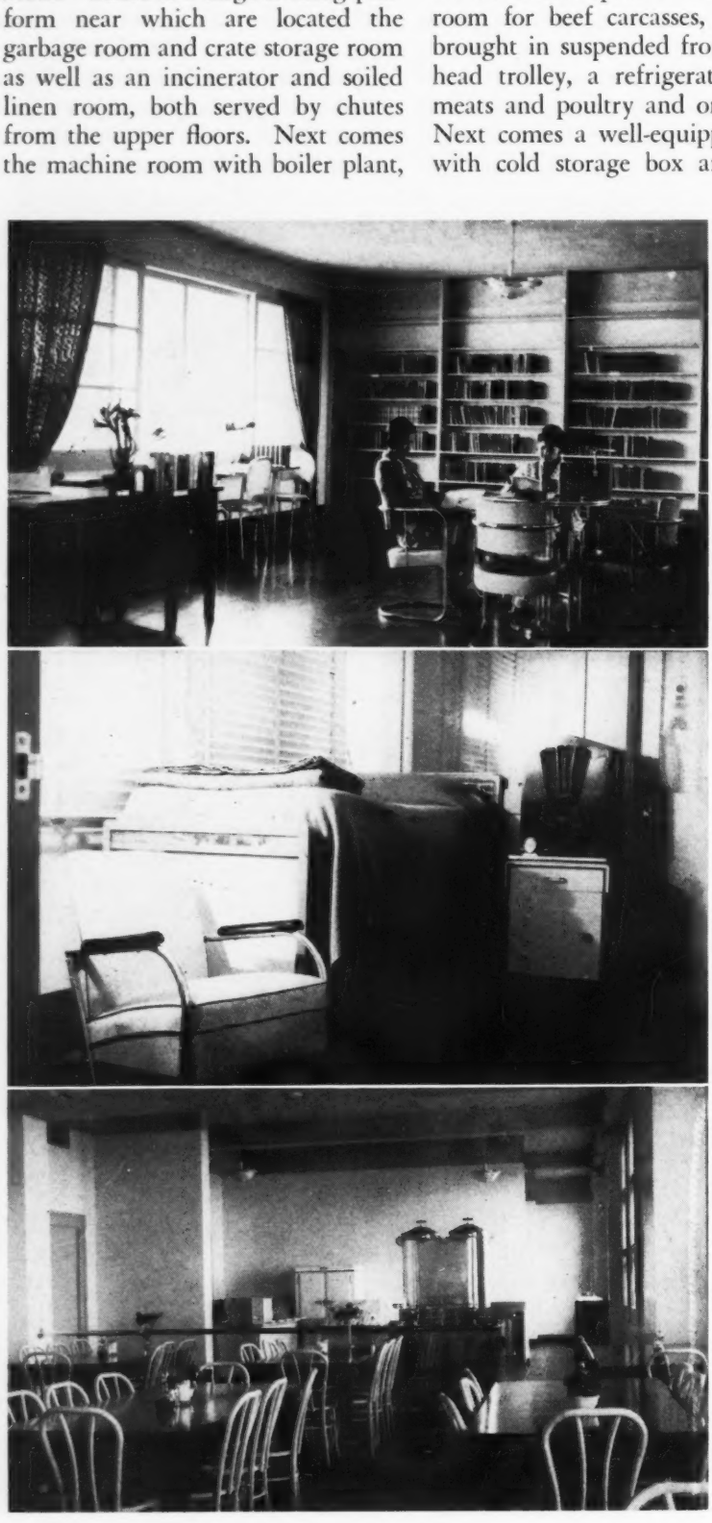
Most of the equipment in the kitchen department is of stainless steel or monel metal, including the hoods over the ranges, steam kettles and dishwashing machines. The floors are of red quarry tile and the walls of the principal rooms are of green glazed tile.

In addition to the kitchen department there are a drug room, linen and blanket room, trunk room, storeroom and a room for medical records.

The upper floors are reached by two electric elevators, one for passengers and one for food wagons, but both large enough to accommodate wheeled stretchers and attendants. There are also four stairways.

The main entrance on the second floor leads to a lobby with information desk, telephone switchboard, superintendent of nurses' room, drug room and visitors' waiting room. Near by are the business office, superintendent's office, assistant superintendent's office, three doctors' offices, each with two examination rooms, a dentist's office and an extensive x-ray department.

On this floor are a children's ward with 10 cubicles, a bath and a dining and recreation room. The walls are decorated with Mother Goose rhymes and pictures. There are three nurses' stations, two utility rooms, nurses' restroom, linen room, janitor's room, alcove for gurneys and two solariums. Wards for women patients include: a 9 bed ward, a 7 cubicle ward, a 3 cubicle ward, two 10 bed



A sunny corner of the spacious library on the fifth floor is shown at the top. Below is one of the private rooms decorated in a cool pastel tint, with furniture and venetian blinds to match. Rooms open on to lanais. At the bottom is a view of one of the dining rooms that opens off the cafeteria.

wards and three private rooms. All wards connect with tiled baths and in each ward are additional lavatories and lockers for each patient's clothing. Two of the wards and the three private rooms open upon screened lanais.

The third floor is for men patients with wards as follows: one 12 bed ward, one 11 bed ward, one 10 bed ward, two 9 bed wards, one 8 bed ward, one 4 bed ward, one 7 cubicle ward, one 3 cubicle ward, one 2 cubicle ward and 9 private rooms with private baths. There is a pneumothorax department near the elevators. Nurses' stations, utility rooms, linen room and other utilities on this floor are the same as on the second floor and include two solariums and five lanais.

The fourth floor contains the surgery department, most of which is artificially lighted and air conditioned. There are five operating rooms including general, chest, minor, tonsils and emergency. Adjacent are two sterilizing rooms, a sterile linen room, a general linen room, a plaster room, a genito-urinary treatment room, a nurses' work room, a utility room, two anesthesia rooms, a supply room, a physiotherapy room, doctors' and nurses' dressing and scrub-up rooms, a nurses' rest room, a nurses' station, and a waiting room for friends. As this floor will be used partly as a general hospital, a labor room, a preparation room and a delivery room were added, together with an isolation department with five private rooms, a bath, a utility room, a linen room, kitchen and lockers. In addition to these provisions, there are an obstetric ward with 4 cubicles and a nursery, two 4 cubicle wards, two 3 cubicle wards and 9 private rooms with baths. The general conveniences and services are the same as the second and third floors, and include seven lanais and two solariums.

On the fifth floor are located the library, the occupational therapy department, a roof garden and the air conditioning plant.

The second, third and fourth floors each have a service kitchen, with stainless metal fixtures and chutes for soiled linen and rubbish. Throughout the hospital all floors except the first are covered with dark green marbleized asphalt tile. The only exceptions are the surgery department, bath rooms, utility rooms, janitor's room and kitchens, where vitreous tile is used. The walls are of smooth plaster on metal lath and metal furring and were given three coats of enamel. Ceilings in general, except in kitchens and surgery, are of acoustic pulp plaster of high sound absorption value.

The chest surgery operating room (top) has vitreous tile floor and walls and is air conditioned. It is one of five operating rooms. Center: Work benches and looms occupy a large part of the physical therapy department on the fifth floor. Bottom: Laboratory is placed on the second floor near examining room.

Exterior walls are of light cream cement stucco over concrete. The roof is of rigid asbestos slate shingles laid over 1 inch of insulation resting on a steel sheathing supported on steel frame.

All sheet metal work is of copper with a verde antique finish. All windows are of the out-swinging awning type and are fitted with venetian blinds.

Rapid Sterilization of Instruments

CARL W. WALTER, M.D.

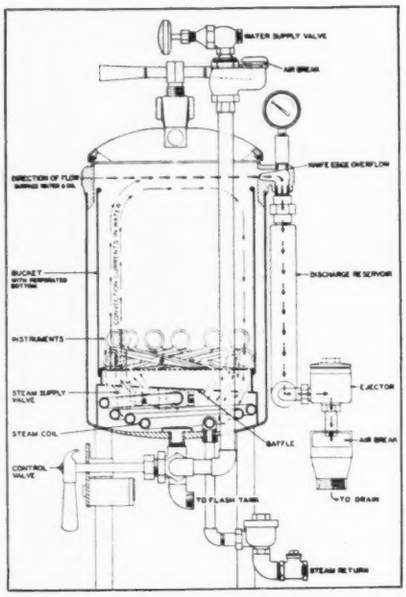
THE cleansing of instruments from septic cases or those soiled by feces, blood or pus containing spore bearing organisms is a problem that has received scant attention from hospital administrators. Nevertheless, the safety of the average sterilizing code depends upon the care with which such organisms are removed mechanically from instruments prior to sterilization, because spores are not killed by the usual sterilizing procedures.

Special methods, particularly nursing procedures, have been devised for the control or destruction of dangerous spores in the operating room. The number of methods in use and the wide range of minimum standards for sterilization of these instruments are indications of the inefficiency of the existing methods of caring for "dirty" instruments.

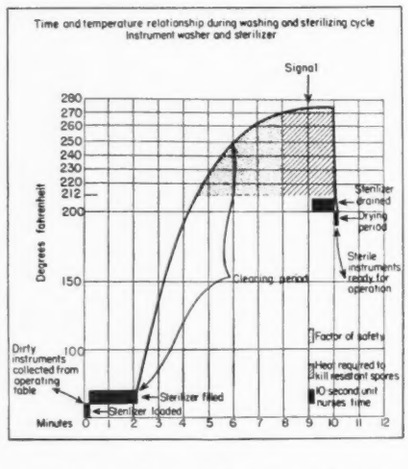
The only safe bacteriologic method among those in current use is that of immersing the soiled instruments in a 10 per cent soap solution and autoclaving them at 250° F. for thirty minutes. This practice has the disadvantage of using equipment primarily designed for another purpose. The interior of the autoclave is usually fouled with soap and denatured proteins, which are spattered on the chamber wall when the steam is vented. The danger of scalding the attendants who remove the instruments from the sterilizer is great.

Soaking dirty instruments in a germicide, prolonged boiling after thorough scouring and scrubbing or combining these in various ways is not only time consuming but also removes the instruments from circulation. Of greater importance to safety, dangerous spores may be spread throughout the operating room during the cleansing process or sterilizers may be contaminated.

A safe, rapid method for the cleansing and sterilization of such instruments is that of exposing them to superheated water in a sterilizer designed to remove the oil and scum



Above: Diagram of the sterilizer that utilizes superheated water as the cleansing and sterilizing agent: Below: Time and temperature relationships of the superheated water sterilizer are charted.



from the surface of the water, leaving at the most a monomolecular film of oil which can be sterilized. This is done conveniently in a vertical autoclave constructed to withstand an operating pressure of 27 pounds per square inch (gauge pressure).

The dirty instruments are collected in a stainless steel bucket directly from the instrument table. The bucket is placed in the sterilizer over a baffle, which forces water to circulate through perforations.

A steam coil, located beneath the baffle, supplies adequate heat for rapid sterilization and sets up convection currents in the water to carry the oil and grease, which leave the instruments and rise to the surface toward an overflow at the rear of the sterilizer. The continual rise in the water level, because of the expansion of the heating water, carries the oils and scum formed by the blood and pus over a knife edge overflow into a reservoir, whence it is discharged into the drain by a special ejector. The addition of a detergent, to peptonize the proteins and saponify and peptize the greases, removes all dirt.

The use of sodium metaphosphate in the detergent* softens the water and prevents the precipitation of a film of alkaline earth soaps and salts on the instruments. The temperature of the water is raised to 273° F. in seven minutes, a signal light indicating when the steam supply is to be shut off.

The superheated water is rapidly drained into a flash tank, exposing the instruments to saturated steam for approximately one minute while the pressure is being relieved. The residual heat in the instruments is sufficient to flash any adherent moisture and the clean, dry, sterile instruments are ready for immediate use upon removal from the sterilizer. The action of this sterilizer is so rapid and satisfactory that it may be used for sterilizing instruments.

*A successful detergent (name on request) now on the market contains:

sodium hexametaphosphate	40
trisodium phosphate monohydrate	15
sodium metasilicate pentahydrate	40
sodium hydroxide	5

When used in the following concentration it will not damage surgical instruments and will sequester the calcium ion and prevent formation of films of insoluble adherent alkaline earth soaps and salts.

Total Hardness of Water as G.P.G.	*CaCO₃* P.P.M.	*Ozs. of Detergent to Add to Sterilizer*
5	85	2
10	171	4.5
15	256	7
20	342	9
25	427	11.5
30	513	13.5
35	598	16
40	684	18
45	769	20.5
50	854	23

G.P.G. = grains per gallon
P.P.M. = parts per million

The Accountant Reports

SIMON TIPPERMAN, C.P.A.

The chief accountant at Montefiore Hospital of New York describes the financial reports which are prepared for guidance of the management

CERTAIN phases of hospital service are reflected in terms of dollars and cents. As such they assume the aspect of ordinary business transactions and are, therefore, subject to analysis and reporting procedure similar to commercial enterprises. Efficient hospital management must have financial reports for its guidance readily available, rendered at regular intervals in the manner that prevails in modern industrial management.

The financial reports of a private voluntary hospital may be divided into four general groups:

1. Financial reports for the guidance of the management.
   a. Reports to the governing board as a whole.
   b. Reports to the executive officers of the board.
   c. Reports to the committee chairmen of the board.
   d. Reports to the administration.
   e. Reports to the department heads.
2. The annual report to the public, particularly the contributing public.
3. Reports to subsidizing organizations.
4. Reports to governmental agencies.

The reports pertaining to subsidizing organizations and to government agencies are, as a rule, standardized. Printed forms are provided in each case and the accounting office of the hospital has no choice but to cooperate by completing these forms as required. However, the foregoing intramural reports listed provide the hospital accountant with a double opportunity; first, directly to apply his professional skill to his immediate task, and second, indirectly to render public service by helping the administration to obtain, assemble and interpret financial statistics. This description will be limited to those reports which are prepared by the accountant for the guidance of the management and, also, to a limited extent, to the published annual report.

The calendar month is the shortest period for which a reasonable accounting is practicable. Since it is essential to render an accounting as often as possible, the financial operations of the hospital should be reduced to figures through the medium of the monthly report which, on final analysis, is the basic institutional report. Since the records of account are the raw material for the report, the latter will be no better than the material from which it is prepared.

Provision must be made in the classification of accounts to facilitate the preparations of reports. In other words, accounts and sub-accounts should be provided with a view toward accumulating the information in a manner readily transferable to the various reports. The monthly report should be sent to all members of the board and to the administration for their information and guidance.

The essential contents of the monthly report of Montefiore Hospital, New York, are:

1. Comparative condensed balance sheet.
2. Reconciliation of funds.
3. Current special funds, income and expense.
4. General fund, comparative statement of income and expenses.
5. Schedule of general fund expenses, city institution.
6. Schedule of general fund expenses, country sanatorium.
7. Schedule of general fund expenses, ladies' auxiliary society.
8. Country sanatorium farm, income and expenses.
9. Cash receipts and disbursements.
10. General funds, comparative statement of income and expenses.
11. Schedule of general fund expenses, city institution.
12. Schedule of general fund expenses, country sanatorium.
13. Schedule of general fund expenses, ladies' auxiliary society.
14. Comparative food consumption statement, city institution.
15. Comparative food consumption statement, country sanatorium.
16. Statistics.
17. Report of admission office.
18. Visits of trustees.

This report opens with "Facts at a Glance." This page was created on the suggestion of a trustee who felt the need for condensing the report of the financial operations of the hospital in a location where it would be most likely to attract attention and at the same time give essential details, which could be studied at greater length in the succeeding pages.

The report continues with the balance sheet for the end of the period. This, too, is compared with the end of the previous year.

The reconciliation of funds presents an accounting for increases or decreases in the endowment fund (principal not to be expended), the building fund and all other special funds for the period of comparison of the two balance sheets, as follows:

Endowment Fund

Balance Oct. 31, 1937	.....
Balance Dec. 31, 1936	.....
Increase in fund	.....
Accounted as follows:	.....
X legacy or contribution	.....
Y legacy or contribution	.....

Current special funds come next in the report. This item presents an accounting of the special funds (prin-

"Facts at a Glance"

Income	*October* 1937	1936	*Increases (black) Decreases (red)*
1. Income earned by the institution			
2. Income from investment allocated to the general fund			
3. Subsidy from Federation. (Charity chest)			
4. Subsidy from United Hospital Fund			
Total Income			
Expense			
1. Payroll			
2. Other maintenance expenses			
Total expenses			
Budgetary deficit			
Received in unrestricted legacies			
Total care days			

cipal and income expendable) for the report period. The following are the headings for this report:

Current Special Funds

Name of fund .....
Expenses .....
Interest .....
Donations .....
Unexpended balance .....

The status of the general fund (corresponding in business enterprises to profit and loss account) follows. This statement presents the income applicable to maintenance of the institution and maintenance expenses in total figures, which are supported by a number of detailed schedules. The general fund accounts, with minor exceptions, are kept on an accrual basis, which is the only modern and scientific basis acceptable in commercial accounting. The following are the headings for this statement:

General Fund—Comparative Statement of Income and Expenses

Particulars .....
Budgetary estimate .....
Actual 1937 .....
Actual 1936 .....

One of the detailed schedules covers the last month of the report only, while another of the detailed schedules covers the period from the beginning of the year to date.

Expense schedules also are provided with the same comparative columns as above. The particulars are arranged in two sections, pay roll and materials, supplies and expenses. Each section has a sub-total.

Cash receipts and disbursements are divided into sections. The first section is identified as "treasurer's accounts" and represents the turnover in the bank accounts which are under the jurisdiction of the treasurer of the hospital. The following will illustrate this section:

1. Balance in banks at the beginning of the month .....
2. Receipts from:
   (List here the principal sources, such as in-patients, out-patients, public charges, legacies, donations)
   Total receipts .....
   Total .....
3. Disbursements
   Transferred to the director's accounts .....
   Investments .....
   Total disbursements .....
4. Balance in banks at the end of the month .....

The next section of the monthly report pictures the turnover in the accounts of the director, or the administrator, of the institution. The prevailing custom of burdening the treasurer, or other voluntary officers, with the signing of numerous checks for current expenses is old-fashioned. It is more practicable, and certainly more efficient, for the chief administrative officer and his immediate assistants to be given this responsibility. With the accounting department certifying the correctness of payments, and with periodic reviews by outside (independent) auditors, there is no reason why such an arrangement should not be satisfactory. The following is an illustration of this section of the report:

1. Balance in the bank at the beginning of the month .....
2. Transferred from the treasurer's accounts .....
   Total .....
3. Disbursements:
   Current accounts payable .....
   Payroll account .....
   Petty cash account .....
   Total .....
4. Balance in the banks at the end of the month .....

Comparative food consumption is dealt with on the next sheet. The accompanying table explains itself.

The remainder of this sheet is shown at the left.

The hospital statistics sheet analyzes the movement of patient population and care days for the month of the report and for the up-to-date period of the same report. A separate

Comparative Food Consumption

Item	*October 1937* Quantity	Price	Amount	*October 1936* Quantity	Price	Amount
Meats						
Poultry						
Fish, fresh						
Fish, canned						
Milk						
Cream						
Butter, other commodities.						

	1937 October	*Jan. to Oct.*	*1936* October	*Jan. to Oct.*
Average number of patients				
Number of care days				
Number of employe days (based on the following averages from the pay roll)				
Resident employes				
Nonresident employes with 3 meals				
Nonresident employes with 2 meals				
Nonresident employes with 1 meal				
Special nurse days				
Per capita cost per person				
Relative increase or decrease				

elaborate report is prepared from month to month which presents all of the hospital statistics, on a comparative basis, which may be of interest to the management. This report is similar for each month.

Department heads are entitled to receive information pertaining to the financial operations of their respective departments. If the institution operates on a budget system it is even more important that the department head know exactly how much already has been spent for his department and how much is still unexpended and available for the balance of the year. For this purpose monthly reports should be prepared in the accounting office for the principal departments. These reports list the various items in exactly the same manner as these items appear in the adopted budget of the hospital.

These departmental reports are considered as the "supplementary reports" to the regular monthly report. Copies of these supplementary reports are handed to the chief administrative officer of the hospital and his immediate assistants, besides the president of the hospital and the chairman of the budget committee of the board of trustees. Copies of individual departmental reports also may be handed to the respective committee chairmen of the board of trustees.

It is customary for private voluntary hospitals to publish an annual report of their activities, including their financial activities. Some of these reports go into great detail, while others omit essential information. It may happen that the treasurer, or other officers of the hospital, will have ideas about the form which the financial section of the annual report should take. In a general way it is best for the accountant to adjust himself to the requirements of those who are in authority. This will save him from making a statement too technical and which may not meet the requirements of the lay leader who is otherwise unfamiliar with the activities of the hospital.

Since the annual report is intended for public consumption, great care must be taken to present the statements, or schedules, in the simplest and clearest manner. It is essential to give an accounting of the various funds and to list all legacies and donations received for the period under review. Some institutions go a step further and list all of the endowed beds and legacies from the beginning of the institution.

While this article is limited to a brief description of various financial reports, it is in order to mention that the hospital accountant must be prepared to furnish information required by the management on short notice. In fact, there is much scope in the modern hospital for the accountant who is endowed with an original mind. As a rule, the good accountant is able to anticipate the statistical and accounting needs of the administrator. On the other hand, even the most capable and willing of accountants may have no opportunity to give the best that is in him, if the chief administrative officer is too busy to review and discuss accounting matters with him, or is indifferent to this essential part of his (the administrator's) work. Rather than ignore accounting problems entirely, as some administrators are likely to do in the limited time at their disposal, it is a good habit to submit special problems from time to time to the independent auditors of the hospital and, also, to the accounting committee of the board of trustees where the administrator always can find help.

From the point of view of business management, no department head can be of greater help to the administrator when these two are able and willing to review and discuss accounting matters with each other. The wise administrator helps the accountant to understand the meaning, in terms of hospital service, of figures that he is called upon to prepare, and the wise accountant helps the administrator to understand the mathematics of the figures that he is privileged to present for the good of the hospital.

Filing Hospital Plans

WILLIAM A. RILEY, A.I.A.

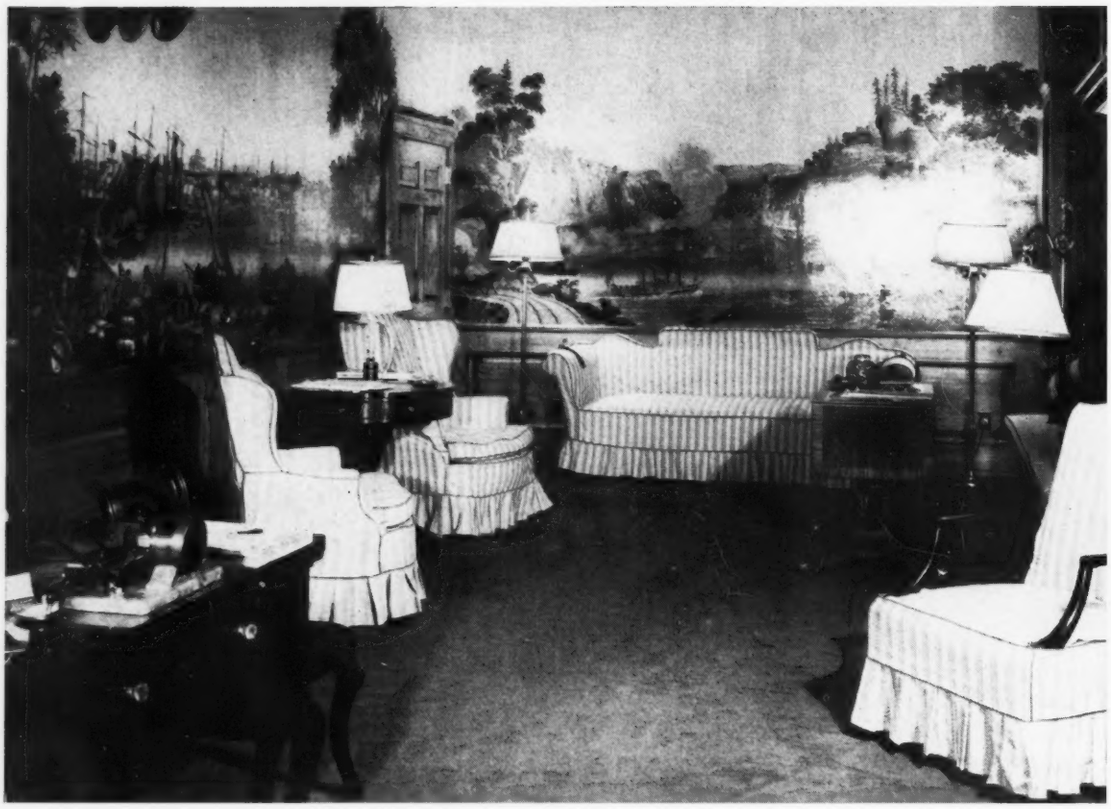
FROM time to time various suggestions and check lists pertaining to general alterations and modernizing of the hospital have been published. Another valuable item could well be added to these suggestions that should be helpful not only to the superintendent and hospital board but to all those interested in any particular hospital.

Every hospital could assemble and file in a convenient location, preferably in the superintendent's office, all plans, specifications and details of its old and new buildings. It has been our experience at numerous times when called upon to consider proposed alterations and additions to find that there were either no plans of existing buildings available or else they could not be found, thereby causing undue delay in solving important and imperative problems. It would, therefore, be a great advantage to all concerned to be able to locate quickly all plans and details that would explain existing conditions in the institution.

In the older hospitals it may be impossible to obtain any original plans or drawings showing the actual building structure, but in the more recent hospitals it is possible to obtain these from the architects.

Aside from the collecting and filing of hospital plans a comprehensive outline or plot plan of the entire institution should be made, a copy of which could be mounted on the wall of either the superintendent's office or board room, where the board, superintendent and hospital personnel could use it for reference and study. This small plot plan, drawn accurately to scale, should contain all the buildings with indications of the various departments, roads, walks and the like, but excluding all structural, heating, plumbing and electric data.

Many business executives have in their offices such plot plans and are thus able to visualize the entire plant at a glance. While a hospital is more than just a business, it still can be operated on business-like lines.



Designed for the Doctors

RAYMOND P. SLOAN

IF A PLANE were to deposit a visitor safe and sound atop the woman's building of the Pennsylvania Hospital, Philadelphia, he would declare there had been some mistake.

"No hospital here," he would insist, regarding with suspicion what appears to be the penthouse of a modern apartment building, the home of someone possessed of both wealth and ideas. Surely it takes a keen imagination to envision an ordinary tenth floor transformed into the replica of an attractive suburban home!

The door stands invitingly open, affording a glimpse of carpeted foyer. Large casement windows on one side of the façade offer further opportunities to examine a room furnished with comfortable chairs and lounges and many soft lights that reveal the rich greens, blues and reds in the scenic wall paper. A smiling young woman in white uniform steps from behind an antique mahogany desk to dispel any doubts.

"Our doctors' suite," she explains. "Won't you come in?"

Pennsylvania Hospital, located in the heart of historic Philadelphia, has taken a portion of the tenth floor of its woman's building and created there an atmosphere completely foreign to the hospital. Here the three chiefs of service have their offices, their only offices. Here they receive their patients in individual suites comprising a main office, two examination rooms with dressing rooms and private hall. Two of the suites are identical. The third is so arranged that the one dressing room serves both examination rooms, the extra space forming an alcove for a nurse-secretary. This arrangement makes it possible for the doctor to examine one patient while another is preparing.

The idea of centralizing the doctors' activities at the hospital was conceived about two years ago. As John Hatfield, administrator, visualized it, the benefits would be manifold. The doctors, by concentrating their work in the hospital, would save themselves time and effort. Their entire day could be spent at the hospital; nights, too, when necessary. Patients confined in rooms downstairs would be assured of having their physicians under the same roof with them most of the time, physicians not exhausted from traveling back and forth from hospital to office.

The hospital, in turn, would be forming a closer tie-up with its staff and strengthening its reputation as headquarters for medical and surgical service. It would also be overcoming the distrust and fear that many patients feel upon entering a hospital.

To the complete satisfaction of doctors, patients and hospital it has worked out exactly as planned. The original cost of renovation and remodeling, estimated at about $40,000, was financed by the hospital. The physicians pay a monthly amortiza-

tion rental, which is less than they would have to pay elsewhere for similar accommodations. This covers light, heat, water, janitor and maid service. Everything else, they supply.

The doctors furnish their own offices and are responsible for their own central organization, comprising receptionist, secretary and nurses. They also provide their own telephone service on the hospital switchboard. This medical telephone exchange, incidentally, is quite elastic in that they can communicate with one another or be communicated with from any part of the woman's building as well as from the general hospital. Every doctor is listed in the telephone book under his own number but must be reached through the hospital exchange. He can also be reached, however, from the outside through the hospital switchboard, using the hospital number.

The doctors' suite is reached by taking an elevator in the main entrance of the woman's building direct to the tenth floor. To the left is the façade of what might easily be taken as a fine suburban home. To the right, forming the south wing, is a solarium. Prior to the alterations, the area used for the elevator lobby included what is now the doctors' waiting room. So when

Top: This might be the entrance to a modern penthouse. Instead, it is the façade of the doctors' suite atop the woman's building of Pennsylvania Hospital. The corridor leading to the doctors' suites is comfortably furnished. Opposite page: The large waiting room.

it became necessary to take over part of the solarium for the waiting room, a new solarium had to be provided. This is solely for the use of patients occupying rooms in the hospital and is not intended for the use of doctors' visitors.

From one end of the large waiting room, which has the atmosphere of a private home, a long corridor leads to the doctors' offices, one suite on one side and two on the other. Off the northwest corner of the waiting room a small office is provided for the clerk who has charge of records and correspondence. Along the wall on the east side is a small laboratory.

The corridor, which runs from east to west, is in reality a continuation of the living room, wide enough to permit furnishing with settees and tables and an occasional chair. These contribute to the homelike, colorful effect. The only professional note to be discovered anywhere, in fact, is the glass plate with the doctor's name inscribed that hangs over the entrance to his suite.

Each doctor has furnished his offices according to his individual taste and preference. There is much similarity between them, however, and the layout, with the exception of the one detail noted, is identical.

Wood paneling is employed, affording a rich background. A wood-burning fireplace fills in a blank wall with a ship's model set in a niche above to add a bit of color. Provision for the necessary reference books is made by bookshelves lining the walls with covered space beneath for storage purposes. An easy chair upholstered in red leather placed in the corner with a good light behind invites comfort and confidence. Near the window is a desk.

Each suite has a private hall providing access to the examination rooms, with dressing rooms adjoining. In addition to the examining table, these rooms are equipped with running water and the necessary furniture. Plenty of closet space is provided.

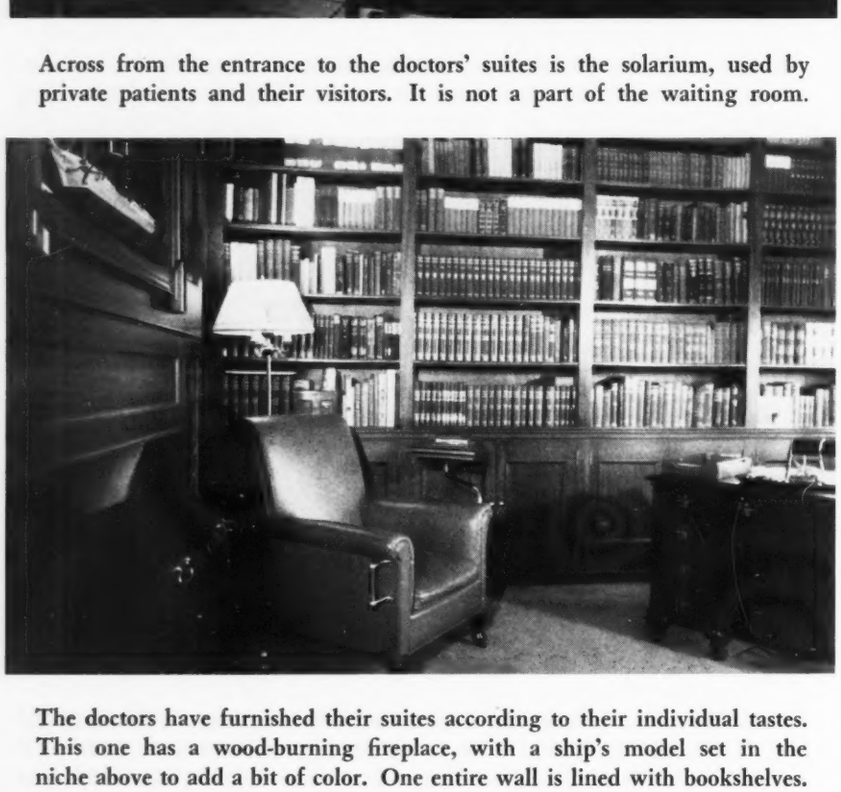
This centralization of service was received enthusiastically from the start. Any hesitancy on the part of patients to make visits to the doctor in the hospital has long since been dispelled. The location of the hospital in the center of the city makes it convenient for women to stop while on their way to or from a shopping expedition or luncheon engagement. They have expressed admiration over the accommodations.

In addition to eliminating much strain upon the doctor by segregating all his work at the hospital, he is spared the inconvenience to his family of maintaining an office at his home. He also finds it possible to maintain better offices at lower cost than would be available elsewhere.

To the hospital it offers distinct advantages in maintaining a closer relationship with its doctors. Pennsylvania is their hospital. It becomes their patients' hospital, too. Patients follow their doctors, as experience has proved.

The financial picture is attractive as well. In eleven years, with the period of amortization over, the tenth floor doctors' home atop the woman's building in Pennsylvania Hospital will be paying a reasonable return. Certainly, that is a prospect any institution may contemplate with satisfaction.

Across from the entrance to the doctors' suites is the solarium, used by private patients and their visitors. It is not a part of the waiting room.



The doctors have furnished their suites according to their individual tastes. This one has a wood-burning fireplace, with a ship's model set in the niche above to add a bit of color. One entire wall is lined with bookshelves.

A Sane Aseptic Technic for Nurses

ALICE ROTHFUS, R.N.

PERHAPS almost as many variations of medical aseptic technic exist as there are hospitals to practice them. All varieties are basically the same and all are practiced for the prevention of the spread of disease, yet each has its own version of the proper method of procedure for the accomplishment of this aim. With the interchange of the great number of general duty nurses in hospitals today, a standard method of procedure for carrying out aseptic technic should be universally practiced. Actually, however, there will probably never be such a standard.

Little progress has been made in our methods of isolation precautions since their recognition as a necessity in the prevention of the spread of communicable diseases. Accepted is the fact that all communicable diseases and all infectious diseases are not transmitted with the same degree of ease, yet most nurses have been taught to treat them with the same amount of precaution. Because the mode of transmission for the various types of disease is known to be through different channels, why should the nurse carry out identical isolation procedures for each disease?

Probably the greatest contributing factors in the lack of progress in the modernization of an old idea have been the irrational attitude of the nursing profession itself and the inherent fear of the spread of disease. The mere fact that the doctor has seldom observed elaborate technic with the same degree of carefulness as the nurse and yet there is little spread of communicable diseases through cross-infection in hospitals proves that much of the commonly observed technic is erratic, therefore, futile.

The reason for much of this precaution has been that nurses allegedly were not capable of differentiation between the types of communicable diseases, therefore, they were incompetent to be trusted to discriminate in the practical application of isolation technic. The result was a rigid technic, designed to cover the most contagious disease, used alike in all cases.

Modern schools of nursing present courses in bacteriology and medical diseases adequate enough to give the nurse a good understanding of the virulence of various organisms as well as a knowledge of the methods of transmission of diseases, making it possible for her to practice technic intelligently.

Surgical asepsis has but one objective. Medical asepsis, however, must necessarily be based on a number of things. The factors that must be considered in drawing up a safe isolation technic might be listed as follows: (1) the degree of communicability; (2) the method of transmission; (3) the protection of the patient, himself, against superinfection with other diseases, and (4) the protection of those with whom the patient comes in contact, particularly patients whose resistance is already lowered, such as those with nephritis, cardiac disease and the like, as well as the hospital personnel.

Contagious diseases may be cared for quite easily in the general hospital where there is no provision for an isolation unit. An excellent practical example of this is being demonstrated at the University Hospitals, Cleveland. Recently, members of the medical staff, in collaboration with the medical nursing supervisors, have drawn up a reasonable outline of transmissible cases, have classified them according to type and have advised the degree of precaution that need be taken to prevent cross-infection. Their classification of these diseases appears in table 1.

Obviously, in a classification of this nature there can be a more sane

Table 1—Classification of Diseases

Group	*Types and Examples*
1	Air-borne, highly contagious: exanthemata, measles, German measles, chickenpox, scarlet fever, whooping cough, influenza.
2	Air-borne, lowly contagious: lobar pneumonia, poliomyelitis, encephalitis, epidemic meningitis, pulmonary tuberculosis, streptococcal sore throat.
3	Food-borne: typhoid fever, paratyphoid fever, amebic and bacillary dysentery.
4	Local infections: syphilis, gonorrhea, tularemia, anthrax, actinomycosis.
5	Parasitic infestation: pediculosis.

Table 2—Personal Precautions for Isolation Technic

Classification	*Technic*	*Close Contacts*	*Moderate Contacts*	*Minimal Contacts*
Group 1 (air-borne, highly contagious)	Rigid	Gown and mask Hands well washed	Gown and mask Hands well washed	Mask Hands well washed
Group 2 (air-borne, lowly contagious)	Slightly less rigid	Gown and mask hands well washed	Mask	No gown or mask
Group 3 (food-borne)	Rigid (yet without fear of infection via upper respiratory tract)	Gown Hands scrubbed	Gown Hands scrubbed	No gown Hands well washed
Group 4 (local infections)	Moderated	Gown Gloves optional	No gown Gloves optional	No gown Gloves optional
Group 5 (parasitic infestation)	Minimal	Gown	No gown	No gown

and logical observation of aseptic technic. Formerly, the nurse was taught that all the diseases in group 4 were to be treated with the same degree of fear and precaution as those of groups 1, 2 and 3.

A practical application of the methods of carrying out this new technic in isolation, according to the classification of the diseases, is shown in table 2 on the previous page.

Table 3—General Precautions for Isolation Technic

Classification	*Linen*	*Gown and Mask*	*Dishes*	*Food, Excreta*	*Medical Apparatus*
Group 1 (air-borne, highly contagious)	To laundry in clean bag marked "contagious"	Discard after each use (autoclave if unsoiled)	Boil 10 min.	None	Disinfect
Group 2 (air-borne, lowly contagious)	As in Group 1	As in Group 1	None	None	As in Group 1
Group 3 (food-borne)	As in Group 1	As in Group 1	As in Group 1	*Food:* Wrap dry food in newspaper and tie securely before discarding. (Boil liquids 10 min.) *Excreta:* Steam in sterilizer for 5 min., rinse, then steam pan again 1 min. Note: Boil bath water 10 min.	Cleanse if grossly contaminated
Group 4 (local infections)	As in Group 1	As in Group 1 (Boil gloves 10 min.)	As in Group 1	None	None
Group 5 (parasitic infestation)	As in Group 1	None	None	None	None

Contacts are described as "close" when the association with the patient is intimate and prolonged, as in bathing the patient or giving treatments; "moderate" when there is little contact except with the hands and for a few minutes only, such as adjusting bedding or helping a patient with a tray (this includes nonprofessional personnel who have occasion to enter the room for cleaning purposes), and "minimal" when there is no contact except with the hands, as a nurse serving or removing a tray or adjusting the bedside table.

General precautions as carried out in this method of isolation technic are listed in table 3.

For diseases in group 1, isolation should be complete in a single room, with doors closed and adequate ventilation. Infections in group 2 require less stringent isolation, which may be carried out on the open ward, if a curtain or screen is kept around the patient at all times. Those in group 3 may be treated on the open ward (screening being advisable as a reminder to use precautions). Those in group 4 present a different problem, the source of infection being the discharge from the wounds, therefore, only directly contaminated articles need be sterilized, either by boiling in alkaline solution (2 per cent NA_2CO_3 solution), by autoclaving or by burning. This group may easily be isolated on the ward. Persons in group 5 with parasitic infestation may be isolated on the open ward.

Terminal disinfection after the discharge of a patient in groups 1, 2 and 3 (highly contagious, lowly contagious and food-borne diseases) consists of:

1. Wash the floor and the walls if the room is to be used for another patient within twenty-four hours; otherwise air the room for twenty-four hours.
2. Wash the furniture and the bed thoroughly.
3. Disinfect all equipment by washing, boiling or soaking in 2 per cent cresol, according to the article.
4. Change the curtains and the screen covers.
5. Air the mattress and the pillows for at least twenty-four hours.
6. Send all blankets to the laundry.

In group 4, the terminal disinfection is moderated:

1. Wash the furniture and the bed thoroughly.
2. Disinfect all equipment.
3. Change the curtains and the screen covers.
4. Air the mattress and the pillows for twenty-four hours.
5. Send all the blankets to the laundry.

Group 5 terminal disinfection requires no more than the following precautions:

1. Autoclave the mattress and the pillows.
2. Clean the room using the same as for a nonisolated patient.
3. Send blankets to the laundry.

The aseptic technic as presented herewith has been practiced entirely successfully since November 1937 in the medical department of the University Hospitals, proving that a well-instructed staff in a general hospital can care adequately for patients with communicable diseases without a unit being set apart for that purpose. The advisability of such a unit for the care of the patients having these infections classified in group 1 is unquestioned, since it may not always be practical to carry out the rigid technic prescribed. In our simplified routine, there is economy of time, energy and equipment; consequently, there must be economy of money.

As nurses, we gladly welcome such a transition from the old methods to the new, for who of us has not resented hands chapped from unnecessary scrubbing with brushes? How many of us have not at some time criticized the differences in the degree of technic used by members of the staff?

It is much more profitable and rational to put into effect a set of simple adequate regulations strictly and universally adhered to than a set of rigid regulations only partially observed. Other medical and nursing procedures progress with the times as our professional knowledge increases; our technics devised to secure medical and nursing asepsis should do likewise.

Uncle Sam Supplies Personnel

W. FRANK PERSONS

THE United States Employment Service has as its chief objective the development of agencies throughout the nation that will serve to bring together the employers who have jobs to fill and workers in search of employment. The local offices which carry on this work are offices of state employment services, which are operated in cooperation with the federal service and which receive federal financial aid. Each office of one of these state employment services is, therefore, an actual part of a national system.

This nation-wide placement service has long been the dream of those interested in social progress in the United States. The present system was created following the enactment of the Wagner-Peyser Act in 1933. A national placement agency has been developed which has helped to bring together the needs of workers and the demands of employers.

The United States Employment Service is the administrative agency that assists the individual state employment services in maintaining uniform operating standards. Each service is staffed by residents of the state and operates under the administrative guidance of a state director. Members of the service personnel are selected on the basis of competitive examinations. Intensive training after entrance on duty increases personnel efficiency and contentment.

How can the employment service help in obtaining workers for hospitals? Actual operating experience has shown that the employment service can be an effective medium for meeting the personnel needs of hospitals, through the referral of applicants with hospital work records.

The employment service has many applicants registered for work as maids, laundry workers, cooks, clean-up men, janitors and orderlies, who are anxious to find steady employment in hospitals, and who, by their work records, have proved that they are qualified for referral to such job openings. Every applicant is carefully selected and re-interviewed according to the employer's specifications before he is sent for a final interview with the employer. By this method, the employment service accomplishes the first rough screening of all applicants. Many valuable hours are saved for a personnel manager, since only applicants who can capably perform the work are sent for the employer's final selection. Thus, instead of interviewing 10 or 12 applicants for a prospective job, the employer chooses from two or three qualified individuals.

The previously registered applicant is called in for a careful re-interview in the employment office before being referred to the employer.

The referral card from the employment office is presented by the applicant to the prospective employer at the beginning of the first interview.

Not only can jobs in the lower brackets be filled by the local employment offices but they also have application cards of individuals wishing more highly skilled work. These workers include carpenters, firemen, engineers, electricians, plumbers, gardeners, stenographers, cashiers, bookkeepers and on down the list of hospital workers.

Trade questions are being developed by the research division of the employment service for use in the local employment offices. These questions enable the interviewers to determine the exact quality of knowledge that an applicant possesses about the type of job for which he claims a proficiency.

The employment service can also help to obtain individuals in highly skilled phases of hospital administration. Competent dietitians, business managers and laboratory technicians can be obtained from almost any local employment office. If the individual is not available locally, the labor resources of the entire nation can be combed, by means of an interstate clearance system, for an applicant who fulfills the employer's specifications.

This procedure is accomplished in the following manner: if an employment service interviewer receives an employer's order for a dietitian, he first scans the cards in the occupational grouping of dietitian. If he finds no registration card that represents an applicant who can qualify for the job, he will immediately forward a description of the job requirements to all the employment offices in his state. If he still fails to find the desired applicant, the employer's order will be sent to all the state employment services. Thus, an order placed in Bangor, Me., may potentially be filled by a well-qualified applicant from Visalia, Calif. To summarize briefly how this procedure helps you as an employer, the labor supply of the United States is as near as your employment office.

Public employment offices all over the country have established themselves as agents for obtaining satisfactory employees for hospitals and for related fields.

For instance, a manager of the local employment office in Mitchell, S. D., canvassed the doctors and hospitals in his city. As a result of these contacts, a file of applicants' registration cards with the blood group noted on them is kept for emergency reference. Only applicants in perfect physical condition are considered. Thus, if blood of group 4 is needed for a transfusion, the employment office can immediately refer the applicant belonging to this blood group.

Registration and Placements in Hospital Work and Related Fields

Personnel	*Registrations Nov. 1937 Active File*	*Placements July 1936 to Dec. 1937*
Physicians	319	143
Nurses:		
Graduate	5,341	1,815
Practical	16,121	14,349
Dietitians	533	176
Anesthetists	7	2
X-ray technicians	166	37
Physicians' office assistants	345	75
Pharmaceutical assistants	41	8
Housekeepers	372	372
Attendants for mental hospitals	617	474
Laboratory assistants, breeders of rabbits and guinea pigs	12	22
Blood donors	3	28
Orderlies	3,179	4,265
Total	27,056	21,746

The Rapid City, S. D., employment office made 20 placements in one week to a hospital in the vicinity. The placements ranged from dietitians to cooks and maids.

In Texas, many offices in smaller localities keep a twenty-four hour service for a nurses' registry. In larger localities, the employment service can supplement the professional nurses' registry by providing interstate clearance when available nurses' registrations are exhausted.

The Des Moines office of the Iowa State Employment Service has developed a cooperative agreement with the hospitals in that city. High school graduates who are interested in the nursing profession and who possess the necessary qualifications are referred by the office to the hospitals for training. Placements of adults in service positions likewise increased.

Employment service workers are eager and willing to aid the medical profession and hospital administrators by supplying any type of worker on the basis of the best qualified applicant for the job. No placements are made on a basis of need but every referral is based on the ability of the applicant to fulfill the requirements.

Trial Period in Administration

E. M. BLUESTONE, M.D.

EVERY hospital administrator knows the wisdom of trial before purchase, except in those instances where he is completely convinced of the adaptability of the article for the purposes.

"Have you tried one of them and are you sure that it is exactly the thing that you want to purchase?" is a question that we frequently ask department heads. Or, "Has anyone, in whose judgment you have confidence, tried one of them successfully under similar circumstances?" Quantity purchasing is dependent on the success of the experimental unit. Otherwise the storeroom will become burdened with obsolete or undesirable equipment. This holds not alone for ordinary merchandise but also for hospital purchases such as pharmaceutical preparations.

Trial use involves a time element and this reminds us of the value of the trial period in hospital administration. A new plan has been formulated on the basis of certain needs. Will it work? Is it safe to put it into effect without qualification when there is more or less doubt as to its applicability or acceptability?

Efficient and economical administration demands that an experimental period be established for changes, because these, after a practical trial over a reasonable period of time, may prove to have been made unwisely. An opportunity for reconsideration, based on a report after a trial period, is a wholesome precaution at any time and should be more liberally provided. One cannot be too careful with expenditures in philanthropic establishments.

Prepayment Plan for Visiting Nursing

CHARLES F. NEERGAARD

A tentative program is outlined as a result of a study of visiting nurse service in Westchester County, New York, to determine the advisability of a group prepayment plan for providing nurses

FOR some years past the Visiting Nurse Associations in Westchester County, New York, have been reluctantly accepting the philosophy of the day, "It's no disgrace to be poor but it's terribly inconvenient." Contributions were steadily decreasing, demands for service were growing and budgets were susceptible of no further cuts without crippling the work. There was, however, one encouraging factor, more people who could pay for hourly visits in the home were calling on the agencies for service.

Some leading spirits from different parts of the county gathered to discuss what could be done. One suggestion that aroused immediate interest was the possibility of organizing a group prepayment plan for visiting nursing similar to the 3-cents-a-day hospital plan. The idea appeared to offer many advantages. It would enable the agencies to broaden the scope of their work, gave promise of a more stable income and, by spreading the overhead over a greater volume, would help carry the cost of free work.

Benefits Middle Group

It would be of great value to families of the middle income group who needed home nursing but could not afford a full-time nurse. To be able to call a part-time nurse when his patient should have one would undoubtedly help the doctor in many instances where expenses were a major consideration, and if the plan could be carried to its logical conclusion, it would provide many more full-time well-paid jobs for nurses. A committee was formed forthwith to exploit the possibilities of a prepayment plan.

A convention of the National Organization for Public Health Nursing was in session in New York City and Dr. C.-E. A. Winslow, professor of public health at Yale, was on the program. Doctor Winslow speaks with the same authority on all aspects of public health and visiting nursing as does Frank Van Dyk of the Associated Hospital Service, New York, on how much hospitalization half a million people will use and how much hospital care 3-cents-a-day will buy.

The committee was fortunate in being able to bring these two authorities together to discuss its idea. They were not only interested but encouraging, and both agreed to help. Anna C. Phillips, widely experienced in hospital, health and nursing surveys, was retained to make the study. The Westchester County conference on group visiting nursing, with representatives from 13 of the 16 county agencies, was organized and study and advisory committees recruited to undertake the study.

The enthusiasm with which the proposal was received is exemplified by the caliber of those who participated, either actively on the study committee or in an advisory capacity. It is significant that not a single one of the busy leaders in the health, hospital and nursing fields who was asked to help refused.

At the outset it was felt that three or four months would be sufficient to obtain the necessary data. But the agencies were so lacking in uniformity of financial and statistical procedure that it proved an almost endless task to assemble and harmonize comparable information as to costs, visits and groups essential for any prospective experiment. Thus, more than a year elapsed before the report was completed.

Two vital factors were to be determined: Is a group prepayment plan enabling self-supporting families to obtain visiting nurse care practicable? If so, what services should it provide and at what cost?

What the Study Covered

To answer these questions, the following subjects were covered in the study:

1. The volume, general character and cost of visiting nurse service in Westchester County, based on the experience of the 13 collaborating agencies.

2. The extent and general nature of the present demand for service, based on their records of 1300 families who had paid for care.

3. The potentialities of service and the extent of its possible use in the after-care of hospital patients, based on the opinion of hospital medical staffs who reported on the further nursing requirements of 1000 patients at the time of their discharge from 30 hospitals within and outside the county.

4. The opinion of Westchester residents on the idea of a group plan for visiting nursing.

5. If it appeared desirable, how could it be accomplished?

The work of the agencies was classified in pay, free and paid-for

groups. It was assembled and reassembled by different types of illnesses: acute, chronic, contagious, maternity and illness among adults and children. It also was considered in its preventive and educational aspects and its correlation with the work of other types of agencies.

The major findings of the survey are as follows:

1. That home nursing is being provided by the 13 agencies at an average cost of $1.40 a visit.

2. That on a population basis the estimated average need is two visits per family annually.

3. That the service to self-supporting families by any one agency does not exceed 9.4 visits per family and that 92 per cent received from one to 10 visits.

4. That, in the opinion of a large majority of Westchester residents consulted, the idea is a good one.

A number of significant facts emerged from the study:

The importance of the problem of the chronic patient in home nursing, which proved to be 42 per cent of the present patient load became evident. This suggested the desirability of subsidiary personnel — practical nurses working under field nurse supervision offering the simpler type of care suitable for many cases, which would allow a greater number of visits under a group plan.

Service Is Inadequate

The inadequacy of the present service was shown in maternity cases: for example, while prepartum, postpartum and new-born infant care is generally well developed, only two agencies in Westchester provide nursing at confinement, and attended but 52 of some 1000 home deliveries in their areas in 1936.

Visiting nursing for post-hospital care, which appears to present possibilities for practical economy, is not being widely used. Reports by physicians on 1002 paying patients discharged from 30 hospitals showed that 298, or 30 per cent, needed follow-up nursing for which visiting nursing would have sufficed. Only 41, or 4 per cent needed full-time nursing. Of the 298 patients who, in the opinion of their doctors, did require nursing after-care, only 14 per cent received this after-care.

The doctors reported that 106 patients could have been discharged from the hospital earlier had visiting nursing care been assured under a group plan with a saving of 832 hospital days and $3500 in hospital bills. Furthermore, a few cases, the doctors stated, would not have had to go to the hospital at all had home nursing been available.

Program Is Outlined

Based on these findings, a tentative program has been formulated as follows:

1. To offer a family membership with service to all members irrespective of age.

2. To limit service to patients attended by a private physician, which should effectively control abuse.

3. To furnish care for all illness irrespective of the stage of the disease and to maternity patients.

4. To provide ten visits per family at an annual family subscription rate of $3 a year (based on an average estimated need of two visits per year at $1.40 each, plus administrative costs).

While the study indicates that the group plan applied to visiting nursing is needed, is desirable and probably would be saleable, it has been felt from the beginning that it would be practical only if organized and offered to the public on a family basis as an extension of the benefits of the group hospitalization plan.

While the plan for visiting nursing service has not been officially presented to the trustees of the Associated Hospital Service, its director has participated in and several of its executives have kept in touch with the study, endorsed its objectives and discussed ways and means of carrying out an experimental program to test its practicality.

To further the plan, the Westchester County Nursing Council has been incorporated with a board of trustees composed of representatives of the various visiting nurse agencies who will furnish the service as required.

The secretary of the county medical society writes:

"The report and its conclusions have aroused a marked interest in the program on the part of all members of the Comitia Minora and an equally strong realization of the far-reaching importance of your program and the potential benefits of a successful trial of the idea. In view of the importance of this proposal and the desirability of its receiving the most careful consideration, the Comitia Minora desires to devote considerable time to the study of this project through a special committee to be appointed in the immediate future." At its September meeting the society approved of the plan for the purpose of an experiment and requested the cooperation of its members in carrying it out.

The private duty nursing group, district No. 13, writes:

"Several members of our board of directors have expressed interest and a desire to study the report. We would like to go on record as being interested in any future program which may be outlined as a result of this study and will greatly appreciate it if you will keep us in touch with the situation."

A public health nursing executive writes:

"Aside from the value for its intended purpose it is certainly a most enlightening study of our county work and brings to view many needs. I want to add my own appreciation of the tremendous amount of time and study put into this project and hope there will be tangible results in better nursing service for the people not only in Westchester but of many other communities."

Considers Practical Details

Legal aspects are being investigated and a joint committee representing the nursing and hospital interests is to consider the many practical details that must be settled before it can be determined whether such a group prepayment plan can be offered to the public.

We are plowing a new field: there are many unknown factors and definite actuarial figures are essential to any general adoption of the plan. It is the hope that, with Westchester County as a proving ground, a year's experiment may be carried on with 5000 of the 22,000 families now members of the 3-cents-a-day hospital plan to yield definite facts on demand, use, cost and value of group prepayment nursing in the home.

Standardized Training Course for Ward Aids

WINIFRED McL. SHEPLER, ESTELLE C. KOCH,
JAMES ALEXANDER HAMILTON, F.A.C.H.A.

IN CITY HOSPITAL, Cleveland, as in most hospitals, training for lay employes has rarely been dignified by a careful plan combining practical work with instruction over a definite period. Rather it has been a more or less sporadic attempt on the part of an overburdened and harassed staff to regiment unskilled employes to learn, as rapidly as possible, how to perform certain tasks which are often tiresome or distasteful, but which, nevertheless, are of vital importance to smooth operation.

Dissatisfied with the expensive, unsatisfactory trial-and-error method of attempting to obtain competent assistants, we decided to do something definite about this problem at City Hospital. We acted on the assumption that any carefully selected group of employes could be developed to serve our needs, if we could arrange to have them definitely trained in groups and supervised until they were properly absorbed into the organization. We believed that standardized group instruction had many more advantages for an institution of our size than the varied individual method. Our experience may be of value to other hospitals faced with a similar problem.

We decided to initiate our program by a course in ward aid training since this was the group that represented our greatest need. The desire to relieve the nurses of an unnecessarily heavy burden of housekeeping duties and to free them for concentration on the more highly skilled nursing duties has long been felt at City Hospital. A shortage of nurses during the current year made the situation more acute than ever.

During recent years several ward maids had devoted the majority of their time in direct assistance to bedside nurses with fairly satisfactory results. A survey of existing conditions brought out the lack of standardization and uniformity of performance of these lay ward helpers throughout the hospitals. It also was apparent that there was considerable inequality in the methods of instruction among the supervisors in the various divisions, as well as a wide variance in the grade of worker selected for such duties. The answer seemed to be to assemble a higher grade, relatively homogeneous group of young women, place them under the direction of one instructor and train them in groups for specific duties.

Realizing that the situation in our own hospital was duplicated in neighboring institutions and knowing that the Cleveland Hospital Council was interested in our common perplexities, we consulted the council and a discussion group was called together. It was decided that sponsorship of any program affecting hospital employes was the logical function of the committee on personnel of the council and this group heartily endorsed the proposal and has maintained a paternal interest in the evolution of the project.

Four other hospitals (Evangelical, Fairview Park, Lutheran and St. Johns), joined by common interests and common problems with the City Hospital, appointed representatives to a subcommittee known as the ward aid committee, which met periodically to formulate policies and to guide the procedure of the training course. Each of the hospitals concerned also appointed student candidates for the course and so evidenced a vital interest in the experiment. These students were expected to return to their sponsor hospital for employment on completion of the training period.

The objectives of our plan were threefold: (1) to define the functions and scope of work of these lay

helpers; (2) to instruct them and develop their skill; (3) to absorb them into the general hospital organization as permanent employes.

The determination of definite duties for these new employes was immediately imperative and appeared to be the most difficult problem. Appropriating the long list of functional activities of the bedside graduate nurse, bedside student nurse and nurses' assistant itemized by the committee on studies of the National League of Nursing Education, the council committee requested the nurse administrators of 18 member hospitals to indicate which of these duties should be performed by graduate nurses, by student nurses or by hospital attendants or helpers.

The committee eventually evolved a list of duties of the ward aid from those duties accepted by 10 or more of the hospitals as applicable to this type of worker. This list of duties is furnished to each head nurse and ward aid with instructions that no deviation is to be made from this standard without written approval by the superintendent of nurses. In spite of many requests for permission to add other duties, to date caution has dictated the denial of any additions.

The question of a title for the new employe who was to emerge from this first course was a debatable one. On each division were pantry maids, cleaning maids and so-called ward maids. Many of the group were to come from the ward maid classification of employe and a definite distinction in title seemed indicated. "Nurses' aid" was suggested but rejected as dangerous because of possible confusion with the professional group. "Hospital aid" was discarded because it did not differentiate the group as being limited only to ward service.

In the end "ward aid" was decided upon as being suitable and consistent with the functions of the position. The ward aid was defined as: "a ward worker who will relieve the nurse of many nonprofessional routine tasks and assist the nurse in the performance of other duties, under the supervision of the professional group and responsible to the head nurse."

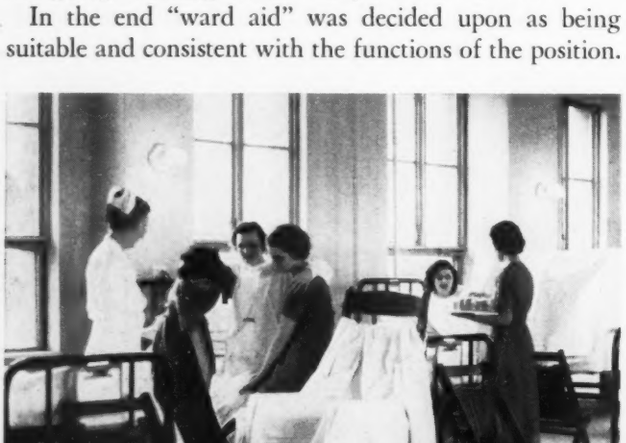
From the first it has been necessary to explain and to emphasize again and again that we are not training practical nurses or a new pseudo-professional person who will be equipped to assist the sick in their homes. Nor is time spent in this course to be credited to nurses' training. We are training employes in their duties at City Hospital and at the affiliating hospitals.

No certificate is given at the end of the training period. Continuance of their employment, the granting of a slight increase in pay and a notation on the permanent personnel record are the only recognition given to their successful completion of the course.

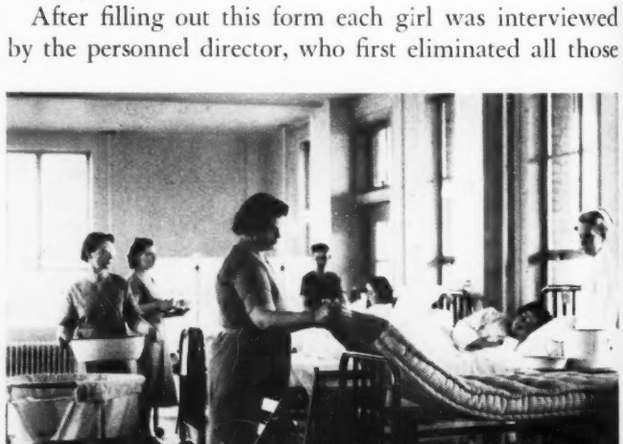
City Hospital lent itself readily to the new school because of its classroom facilities and the variety of divisions adaptable for ward practice. This municipal institution is an acute general hospital of 1600 beds, with about 1400 employes and with separate divisions for medical, surgical, obstetric, tuberculous, psychopathic, contagious and out-patient cases.

It was our belief that this type of position, particularly if enhanced by definitely planned training, would appeal to a number of young women of high school age who are groping for a specific occupation. Some publicity was given the proposed course, with the result that early in August 1937 approximately 600 applicants appeared for interview. A simple application form was devised for recording pertinent data regarding each person applying.

After filling out this form each girl was interviewed by the personnel director, who first eliminated all those



Instruction in the proper method for moving a patient from the bed to a chair is a part of the training course.



There is a right way to clean and turn a mattress on a check-out bed, as these ward aids learn in the classroom.

Above: Before starting the course there is a conference with the instructor. Below: They learn how to handle food.

Above: Learning ways in which to make the patient comfortable. Below: Instruction in duties of the utility room.

who did not fall within the required age limits of 18 to 35 years or who did not have the minimum educational qualifications of two years of high school.

Those who successfully passed this first screening process were then interviewed by the assistant superintendent of nurses and the instructor of this course, who considered the applicant's probable adaptability for the work. Finally, the survivors were seen and ranked jointly by the superintendent of nurses, the assistant superintendent of nurses, the instructor and the personnel director.

As sound health is essential to success in this venture each approved applicant was given a physical examination, which included laboratory tests, x-ray studies of the chest, tuberculin tests and vaccination. Only three applicants were rejected because of unsatisfactory health status. At the end of this series of eliminating processes 120 successful candidates were finally enrolled.

We decided that this first experiment should be carried on over a period of six months. The course of instruction is planned for 31 hours of formal classwork and 144 hours of ward practice, or a total of 175 hours of intensive teaching and supervised practice. Conference periods with the instructor and some coaching periods also are provided. The eight hour day and forty-eight hour week, including classroom hours, were established to comply with existing laws for female labor.

Classrooms suitable for seating the 120 girls are available in the small theater of the psychopathic building and a vacant division of the same building is used for ward practice lessons. The subject matter of the course includes: (1) the hospital organization in order to orient the student to her new complex environment; (2) the aid's relationship to the hospital organization; (3) her personal health and hygiene, for her general information and protection, and (4) her duties as an aid.

Practical demonstrations of ward duties and personal experience in performing these duties are given before the aid is assigned to any ward. Ward practice is arranged in different departments of the hospital to give the students a widely varied experience.

Written tests are given during the course and a final examination is held at the end of the training period. A passing grade of 70 is necessary for continued enrollment and all grades become a part of the aid's permanent personnel record. In assigning final grades 30 per cent is allowed for classwork, 20 per cent for ward demonstration and 50 per cent for actual performance.

In making first assignments to the divisions, the aid's preference is considered as far as possible. However,

rotating services are scheduled in order to improve each girl's skill and adaptability, to the end that she may be useful in any department. From four to six weeks is the usual length of time on a given division, with occasional transfers for the good of the service.

Aids assigned to the tuberculosis service remain three months because there they may have experience with both medical and surgical patients. Only those who show positive tuberculin reactions are assigned to this unit. Assignments, issued daily by the head nurse, cover day and relief hours. The aids are not assigned to night duty until the course is completed.

While on the ward the aid is under constant supervision by the professional group and is frequently observed by the instructor. When first assigned to a division the aid flounders and needs considerable help until she learns the divisional routine and gains self-confidence. The head nurse on each division devotes an average of one hour daily to her ward aid group. Efficiency reports regarding each aid are made out by each head nurse using a standard form. She also checks the Record of Practical Work card and indicates the practice that the aid has had in certain processes, to correlate actual experience with classwork learning.

The ward aids are given three meals a day, served in a dining room exclusively for their use. Quarters are not provided. Monetary compensation is at the rate of $49.50 a month, the same rate as for the ward maids. On entering the course, the aids become temporary employes of the hospital; successful competition means permanent employment and a $5 a month increase.

In an effort to develop the pride of group consciousness, special uniforms have been designed for these workers. Each aid has six uniforms provided and laundered by the hospital, which enables her to have a clean one every other day. The uniform is a plain cinnamon brown cotton model with short sleeves and a V neck.

Considerable time has been spent in discussion with nursing leaders to obtain the benefit of their guidance and also to prevent misconceptions of our activities based upon erroneous fact or rumor. Although nursing groups on the whole have been receptive to the need of a well-trained employe, such as the aid, individuals within this group have feared that formal classroom instruction and ward practice would develop a class of pseudo-nurses whose status would always be a menace to the profession. On three different occasions details of the course have been presented to our district assembly of the Ohio State Nurses Association for suggestions and advice. Many nurses visited the classrooms.

The older nurses who have suffered through the periods when untrained lay helpers, volunteer and paid, have invaded the wards, leaving chaos in their wake, shuddered at the idea of having to supervise this new source of grief. However, with characteristic adaptability, when they were shown that the ward aids' program was systematized to produce a capable, versatile assistant who could go from one service to another with the minimum of friction, the nursing force, without exception, gave its approval.

One general duty staff nurse commented, "I know that I am doing better nursing now; I am able to do the little nice things of nursing for which I never had time before." This seems to express the sentiment of many.

The attitude of the medical man toward the innovation can perhaps best be illustrated by the following statement: "These new employes have entered the service in an unobtrusive manner. Since their addition there is less grumbling by nurses when procedures are prescribed and more procedures are completed on time."

There was some apprehension on the part of the nursing supervisors who anticipated friction between the ward aids and the other lay help, such as the orderly, the kitchen maid and the cleaning force. Many of these older employes who had been accustomed to assist the nurse with certain semitechnical tasks and had derived great satisfaction from the prestige to which they felt these duties entitled them resented the newcomers.

Gradually, however, when they realized that the aid had a definite routine assigned to her without any authority or supervisory power over the other lay workers, she was accepted, even welcomed, into the ward family by most of the other employes. Occasionally we hear of some tension arising from overbearance on the part of an older ward maid but of no serious quarrels.

Table 1—Program for Instruction of Ward Aids

Subject Matter	*Hours*
Lectures	
Human relationships	7
Personal health	10
Duties	23
Final examinations	2
Demonstration and group practice	56
Divisional supervised practice	144
Total	242

Patients testify they have been able to receive many more comforts and prompter service since the introduction of the ward aids.

The reaction of the ward aids themselves has been of absorbing interest. Many of these young women had the ambition to enter nursing and would no doubt have attempted to enter training had circumstances, usually financial, permitted. Many of them are using the course as a stepping stone to nurse training.

A few have indicated that there is keen resentment on the part of several students because they feel that there is too much class distinction in a hospital. Probably it is inevitable that in so large a group a few would lose perspective regarding their place. On the other hand, perhaps, we, in our enthusiasm for the experiment, painted too glowing a picture of the joys of domestic work on our wards. After all, there is not much glamour

to cleaning and bed making, even if they are an expression of devotion. Undoubtedly the continuance of their interest will be one of our perplexing situations.

One of the problems in beginning classwork instruction was the lack of any textbook covering the subjects to be taught. It was, therefore, necessary for the instructor to begin preparation of reading material suitable for student use. Mimeographed sheets were prepared giving selections from books on personal health, human relationships and duties of the ward aid. The bibiographies are printed at the end of this article.

Other practical problems encountered in assimilating this class of employes relate to their physical welfare. Classrooms, dining rooms and rest rooms had to be found and equipped. The health of the workers is observed as closely as possible by the instructor and the personnel physician. Provision for teaching good health habits to ward aids includes a health inventory; instruction in posture and diet, physical cleanliness, elimination, respiration and speech, promoting good circulation, and care during the menstrual period.

One difficulty, which seems inevitable, has been the resignation of some of the chosen few. An analysis of these cases show the following:

August 15 to September 14	14
September 15 to October 14	5
October 15 to November 14	5
November 15 to December 14	5
Total	29

As might be expected the largest number of resignations were received in the first month. Of the 29 who left, eight have been from the affiliating hospitals.

The first class of ward aids at Cleveland City Hospital has completed the six months' training course and the students have been given permanent assignments as employes either of this hospital or of their respective affiliating hospitals.

As originally planned the course of instruction was to consume 175 hours of instruction. A revised program has been worked out as shown in table 1.

Demonstrations and group practice are held in the classrooms. Divisional supervised practice consists of a practice period conducted daily by the head nurse for the ward aids on her particular division, after consultation with and guidance by the instructor.

Table 2—Hours of Instruction, First Period

Subject Matter	*Hours*	
Lectures and examination		
Human relationships, hospital organization	3	
Duties of aids		
Preparation of ward unit	1	
Bed making	1	
Bed making with patient	1	
General review	2	
Examination on practical work	1	
Discussion of examination	1	
Total		10
Demonstration and group practice		
General instruction and registration	2	
Trip through hospital	2½	
Trip through hospital unit	1½	
Preparation of ward unit, demonstration	2½	
Preparation of ward unit, practice	14	
Bed making, demonstration	2½	
Bed making, practice	30	
Total		56
Divisional supervised practice		12
Grand total		78

Table 3—Hours of Instruction, Second Period

Subject Matter	*Hours*	
Lectures and examinations		
Duties of the aid		
Bed bath	1	
Bed bath demonstration	1	
Uniform and mineograph sheet distribution	1	
Examination on theory	1	
Service unit	1	
Diet kitchen	1	
Patient up in bed	1	
Diet trays	1	
Laundry and linenroom	1	
General ward supplies	1	
Admission of patient	1	
General review	5	
Total		16
Health of aid		10
Human relationships		4
Final examinations		2
Total		32
Divisional supervised practice		132
Grand total		164

The instruction is divided into two periods. There is a two week period of intensive class instruction averaging five hours per day in class. The hours of instruction are shown in table 2.

During the second less intensive period, which averaged two hours per week in class for the remaining five and one-half months, the hours of instruction are shown in table 3.

Time was lost for holidays and the schedule was interrupted by emergencies. The figures shown in tables 1, 2 and 3 do not include hours spent in coaching periods for slow students and for those who lost time and also for supervision of those who did not adjust themselves normally to the course of instruction.

The usual scale of grades is used for the separate divisions of theory, efficiency reports and practical demonstrations. However, the final composite grade is weighted as follows: efficiency reports, 50 per cent; theory, 30 per cent, and demonstrations, 20 per cent.

In this first group of students the theory grades ranged from 29.52 per cent to 15.52 per cent, (the latter, the performance of a student who did exceptional work on the wards but who had difficulty throughout the course in her class work). Demonstration grades ranged from 48 per cent to 41.66 per cent. Final composite grades ranged from 96.18 per cent to 80.14 per cent.

Record of Practical Work **Exhibit 6a**

Name Class---Ward---Aide

Precedures	Class	Pract	work	Precedures	Class	Pract	work
Care of Room and Ward				Care of Clothing			
" " Plants and Flowers				" " Valuables			
" " Service Rooms				Moving-Lifting			
Bed Making Without Pt.				In bed to Chair or			
" " With Pt.				Stretcher			
Post Opr. Bed				Use of Pillows			
Fracture Beds				Pads Sand bags-etc.			
Care of Beds and Bedding				Use of Back rest			
				" " Cradles			

Summary Card

Precedures	Class	Pract	work	Precedures	Class	Pract	work
Morning Toilet				Shampoo			
Tub Bath							
Bed Bath							
Evening Toilet							
Giving Removing							
Bed Pan				Remarks:			
Feeding pts.							
Care of Mouth							
" " Back							

The head nurse on each division fills out cards giving a record of the practical work taught in the classroom and on the wards, to indicate experience. Front and back of the permanent record card appear above.

In her final report the instructor writes a brief analysis of each aid's performance, sketching the strong and weak points of each as objectively as possible and indicating on what services each girl had her training. Similar analyses, with a record of class hours and grades, are sent to the affiliating hospitals concerning their students.

As far as it is possible to arrange, each aid is given service on the division of her choice. There were the inevitable experiences of disillusionment and occasionally a student registered relief on leaving a division which she herself had chosen. A few skillfully manipulated transfers undoubtedly saved a number of resignations.

In this first class each aid whose reaction to the tuberculin test was positive had a period of service in the tuberculosis hospital, following which several students requested assignment there. All had some experience on both male and female divisions and with the babies.

The efficiency reports from the division head nurses are generously commendatory in many cases. The work cards are attached to the permanent record card and we have an adequate story of each aid's experiences and performance.

The ward aid is established now as a permanent part of the hospital organization. No longer a student, she has acquired a status that is recognized by all the other departments. It was significant to those of us who have believed in this training course that one of the nurses who at first was quite militant in opposing the student ward aid group asked whether a near relative might be accepted for the second class. One of our nurses has applied for a place for a friend.

The head of the laboratory department requests that specimens for the laboratory be entrusted to the aids whom he feels to be more dependable than the untrained orderlies. The comments of our visiting doctors on the character, appearance and abilities of these workers are laudatory.

Head nurses who formerly spent many hours in instructing new lay employes during their first weeks testify to the great relief and joy on receiving well-trained workers who go about their duties with interest and intelligence. Supervisors voice their wrath when one of these trained workers is transferred to any other division and replaced by an untrained lay worker.

Executives of the nursing force believe this plan to have resulted in the greatest improvement in bedside care experienced in this hospital for more than a decade.

Patients (including nurses who are ill) comment freely on the excellence of the service afforded by the aids. Relatives of patients express a noticeable lessening of the rush and tension on the ward following the inception of these workers.

Eager, docile and pliable during the exciting training period, these young people have to assume responsibility for a round of routine tasks which may in time become unbearably monotonous to a few. Protected by their student status and interpreted by their instructor during their initiation on the wards, they are learning now to stand on their own feet in the difficult give-and-take of ward life.

It is natural for the ambitious young women, trained in certain skills, to want to use them until the novelty wears off and then to attempt to acquire new skills. By the very nature of her position, the ward aid must curb such tendencies and be satisfied to continue to try to perfect herself in the skills that her assignments permit, rather than to forge ahead to new accomplishments. For this reason we believe that the ultimate test of the young aid's stamina and the final demonstration of her worth to the hospital are yet to come.

Of this first class 20 have planned to enter nursing training. Several of them have been accepted. If it were not for financial responsibilities at home a number of others would also plan to go into professional training. It has been gratifying to observe how these young people have been determined and willing to forgo immediate pleasures in their drive toward the higher goal.

For the present City Hospital has found it well worth the effort and expense to have conducted this first training course for ward aids. A second course for another group of aids will follow as soon as arrange-

ments can be made; two courses a year are contemplated as part of the future program.

The vocational guidance directors of the high schools of Cleveland have been eager to learn more of this opportunity for young women unable to enter nursing for reasons of finance or education. They inform us that this work has attracted many of their students.

For months the nursing, ward aid and personnel offices have been receiving letters, phone calls and personal inquiries from girls in Cleveland and other cities and towns regarding the procedure required for entrance to ward aid training. Friends and relatives of the students and of our patients have come in large numbers.

Unsuccessful applicants to the first class have returned begging for another chance. New applicants have been sent to us from schools, social agencies and civic leaders. At the moment there are 675 applicants from outside our own organization. However, the present intention is to enroll a larger proportion of our own ward maids and other personnel in the next class.

Assured by the excellent results of this first experiment a similar course for orderlies will be started simultaneously with the second ward aid group.

The following duties of a ward aid will be performed in connection with convalescent patients. Assignments are to be given daily by the head nurse. The ward aid may assist the nurse in caring for other patients only upon request of the nurse and under constant supervision of the nurse assigned to such a patient.

Patients

1. Assist in admission of patients, listing clothing and valuables.
2. Assist in moving and lifting patients into bed and to chair or stretcher.
3. Make patients comfortable by adjustment of pillows, pads, air cushions and sand bags.
4. Learn the purpose of back rest and cradles.
5. Feed helpless patients if they are not under isolation.
6. Give patient daily routine care, such as changing gown, arranging blankets, distributing clean hospital linen, cleaning and filling water pitchers for patients on unlimited liquids, taking patient to bathroom, to x-ray, to clinics, and duties of like nature, assigned by the head nurse.

Beds

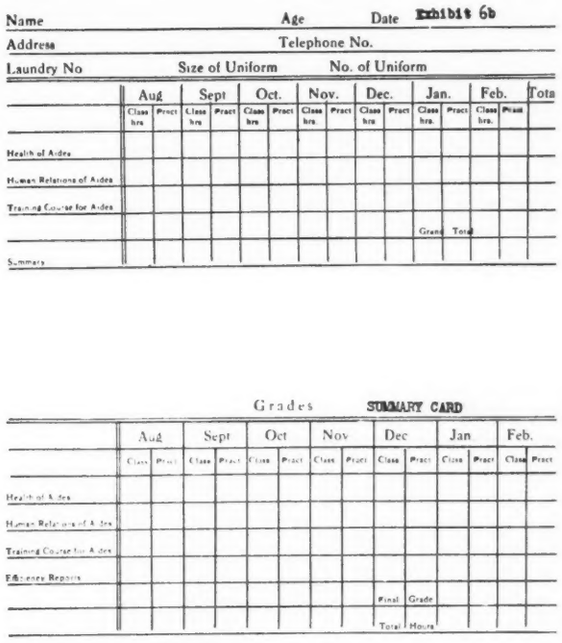
1. Make unoccupied beds.
2. Make bed occupied by patient.
3. Make ether beds.
4. Make fracture beds.

Baths

1. Carry water to patients for morning and evening care.
2. Assist patients with morning and evening toilet.
3. Assist patients who are ordered tub baths, cleaning the tub and bathroom after the patient has returned to the ward.
4. Care for patients' hair, shampoo it and report and treat patients for pediculosis.
5. Give bed bath to patients who are not in a critical condition.
6. Care for teeth, mouth and nails of patients.

Medical and Surgical Supplies

1. Clean saline flasks and bottles and similar containers used on the ward.
2. Prepare test tubes, flasks and bottles for sterilization in the autoclave.
3. Cut gauze for dressings. Make dressings, wrap and prepare them for sterilization.
4. Wash rubber gloves and rubber sheets. Learn the routine care for gloves and sheets before placing them in supply closet.
5. Learn how to scrub instruments.
6. Learn procedure for cleansing sterilizers and their general use, how to turn them on and off, and how to lift the lids.
7. Learn to place supplies in an autoclave and remove them.
8. Keep ward baskets clean and filled with required articles for daily care.
9. Give a patient under observation an emesis basin but never empty it without permission from the nurse in charge.
10. Learn to care for ice caps and hot water bottles.



Name Age Date Exhibit 6b

Address Telephone No.

Laundry No Size of Uniform No. of Uniform

	Aug		Sept		Oct.		Nov.		Dec.		Jan.		Feb.		Tota
	Class hrs.	Pract	Class hrs.	Pract	Class hrs.	Pract	Class hrs.	Pract	Class hrs.	Pract	Class hrs.	Pract	Class hrs.	Pract	
Health of Aides															
Human Relations of Aides															
Training Course for Aides															
											Grand	Total			
Summary															

Grades SUMMARY CARD

	Aug		Sept		Oct		Nov		Dec		Jan		Feb.	
	Class	Pract	Class	Pract	Class	Pract	Class	Pract	Class	Pract	Class	Pract	Class	Pract
Health of Aides														
Human Relations of Aides														
Training Course for Aides														
Efficiency Reports														
									Final	Grade				
									Total	Hours				

Remarks

Front and back of ward aid's personal record card, covering health, personality, efficiency and work covered in demonstration classrooms and in divisional practice periods conducted daily by the instructor.

11. Wash surgical cart and keep it supplied with equipment according to the list.

12. Cleanse all treatment trays and keep trays supplied with equipment according to the list.

Clerical Work

1. Rule the order book and forms as requested by the head nurse.
2. Assist the head nurse in inventory.

Diets

1. Assist the nurse in preparing and serving trays.
2. Assist the patient with his tray.
3. Collect trays.
4. Wash glasses and drinking tubes.
5. Prepare the tray for following meal; clean napkin, tray cover and dishes.
6. Fill the patient's request for a second serving of bread, butter and the like, after consulting the nurse.

Housekeeping

1. Clean the ward and ward equipment.
2. Align the beds.
3. Clean ink wells and keep them filled.
4. Keep utility supply and bathrooms clean.
5. Clean the refrigerator, stove and sink in the kitchen.
6. Clean mattresses; place them on the porch for sunlight and return them to the bed.
7. Change screen covers.
8. Count used linen. (Do not handle contaminated linen after its removal from a bed.)
9. Count clean linen.
10. Fold linen.
11. Fold and bag linen for the autoclave.
12. Check and put away household supplies.
13. Keep all utensils clean.
14. Empty waste paper baskets.
15. Keep wheel chairs and stretcher carts in the space assigned to them.
16. Care for flowers.
17. Keep the drug box in perfect condition.
18. Wash masks used on the ward.
19. Wash out soiled sheets before placing them in the laundry bag.
20. Keep the window sills clean.
21. Turn on the ward lights at the time assigned by the head nurse in the evening.
22. Turn off the ward lights at the time assigned by the head nurse in the morning.
23. Keep the kitchen supplied with dish and drying towels.
24. Keep all paper towel containers filled.
25. Keep all diet and supply carriages clean.
26. Keep the utility room supplied with clean bedpan covers.
27. Keep all liquid soap containers filled.
28. Clean morgue baskets and keep supplies as outlined on list attached to the basket.
29. Answer lights if the nurses are occupied, referring request to the nurse if other than assigned duty. Disconnect the signal after answering the call.
30. Thoroughly cleanse and boil rubber nipples. Boiled nipples invariably are to be handled only with sterile forceps.
31. Wash all nourishment dishes.
32. Check supplies for the night nurse except medicines and report a shortage to the head nurse.

Miscellaneous

1. Distribute mail to patients.
2. Show visitors to patients' rooms.
3. Notify the house staff of phone calls.
4. Look for any person for call as requested by the charge nurse.
5. Collect visitors' passes.
6. Take specimens to the laboratory.
7. Perform errands upon request of the nurse in charge.

PERSONAL HEALTH

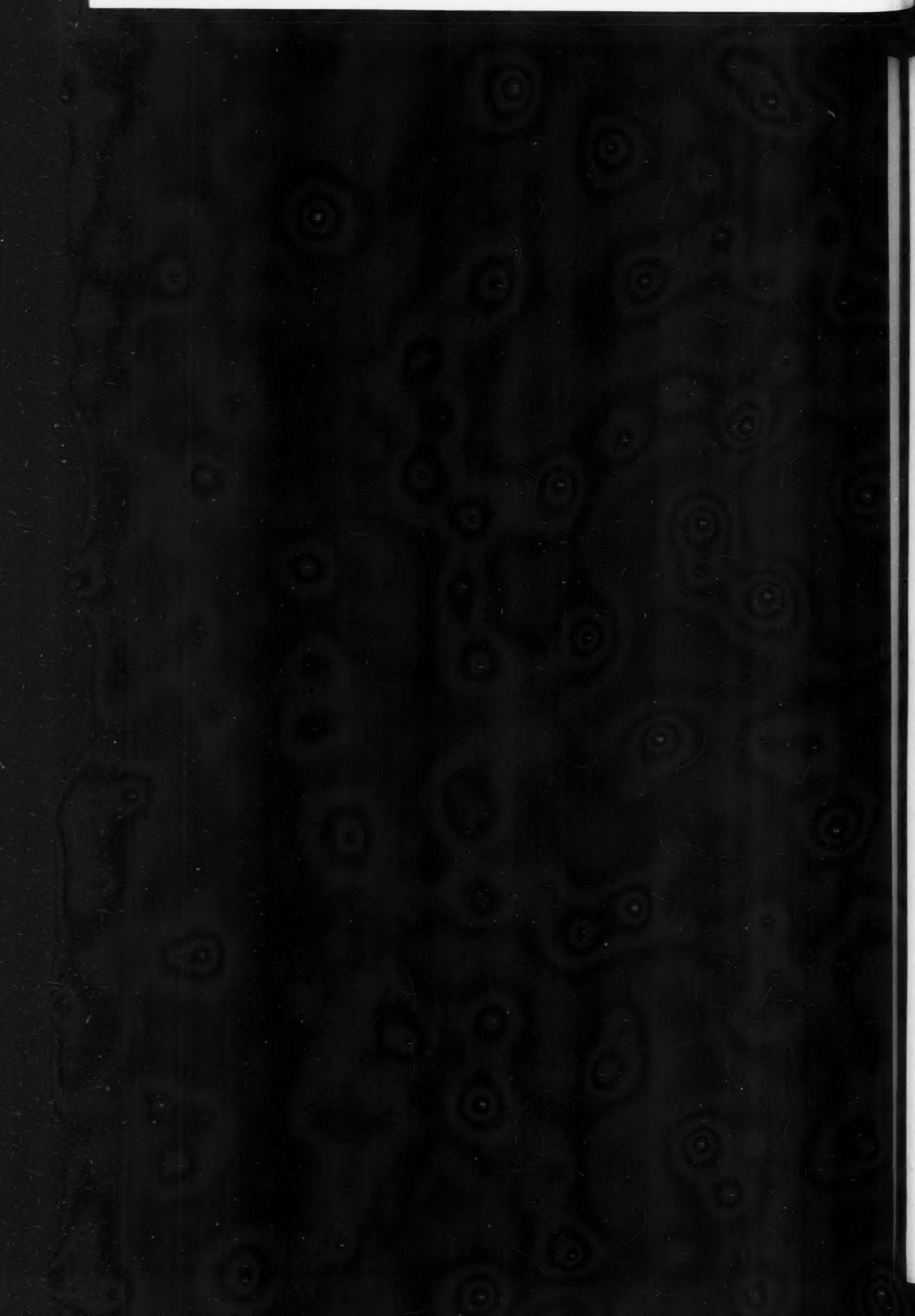
Krueger, Walter W.: Fundamentals of Personal Health, W. B. Saunders Company, Philadelphia, 1936.
Smiley, Gould and Melby: Principles and Practice of Hygiene, The MacMillan Company, New York, 1930.
Egbert, Seneca: Personal Hygiene for Nurses, F. A. Davis Company, New York, 1930.
Bunkers and Turner: Personal Hygiene for Nurses, C. V. Mosby Company, St. Louis, 1929.
Sharp, William Barnard: Foundation of Health, Lea & Febiger, Philadelphia, 1930.
Harmer, Bertha: Principles and Practices of Nursing, The MacMillan Company, New York, 1936.
Smith and Colleagues: Principles of Nursing Care, J. B. Lippincott Company, New York, 1937.
Shepard and Lawrence: Textbook of Attendant Nursing, The MacMillan Company, New York, 1935.

HUMAN RELATIONSHIPS

Shepard and Lawrence: Textbook of Attendant Nursing, The MacMillan Company, New York, 1935.
Harmer, Bertha: Principles and Practices of Nursing, The MacMillan Company, New York, 1936.
Smith and Colleagues: Principles of Nursing Care, J. B. Lippincott Company, New York, 1937.
Talley, Charlotte: Ethics, G. P. Putman's Sons, New York, 1925.
Aikins, Charlotte: Studies in Ethics for Nurses, W. B. Saunders Company, Philadelphia, 1930.
Parsons, Sara E.: Nursing Problems and Obligations, Whitcomb and Burrows, Boston, 1916.
Robb, Isabel Hampton: Nursing Ethics, E. C. Koeckert, Cleveland, 1914.
Garesché, Rev. Edw. F.: The Soul of the Hospital, W. B. Saunders Company, Philadelphia, 1928.
Gladwin, Mary E.: Ethics, A Textbook for Nurses, W. B. Saunders Company, Philadelphia, 1937.
Harrison, Gene: Ethics in Nursing, C. V. Mosby Company, St. Louis, 1932.

DUTIES OF THE WARD AID

Hurst, Nora P.: Hospital Housekeeping and Sanitation, C. V. Mosby Company, St. Louis, 1926.
Shepard and Lawrence: Textbook of Attendant Nursing, The MacMillan Company, New York, 1935.
Smith and Colleagues: Principles of Nursing Care, J. P. Lippincott Company, New York, 1937.
Price, George M.: Hygiene and Sanitation, Lea & Febiger, Philadelphia, 1936.
Smiley, Gould and Melby: Principles and Practices of Hygiene, The MacMillan Company, New York, 1930.
Harmer, Bertha: Principles and Practices of Nursing, The MacMillan Company, New York, 1929.
Maxwell and Pope: Practical Nursing, G. P. Putman's Sons, New York, 1914.
Aikens, Charlotte A.: Primary Studies for Nurses, W. B. Saunders Company, Philadelphia, 1912.
Goodnow, Minnie: The Technic of Nursing, W. B. Saunders Company, Philadelphia, 1930.
Goodnow, Minnie: First Year Nursing, W. B. Saunders Company, Philadelphia, 1914.
Cleveland City Hospital, Nursing Procedure Book.



Handling Mental Patients

JOSEPH C. DOANE, M.D.

Ways in which the development of mental symptoms in general hospital patients may be detected and methods of treatment are discussed by the editor in the final of two articles

A DEFINITE defect exists in the system of nurse and intern education in the average general hospital because such institutions rarely possess affiliation with those hospitals handling a large number of mentally ill patients. As a result, graduate and undergraduate nurses as well as interns often fail to recognize psychopathic symptoms and hence fail to take such precautions as are necessary to the patient's welfare.

Most institutions have definite rules relating to the admission of depressed, maniacal, epileptic and alcoholic patients. Too often these rules are so rigid that admission of such cases is promptly denied, even though the individual and community need of such patients may far exceed that of such medical and surgical conditions as pneumonia and appendicitis. We do not suggest that the general hospital should routinely admit patients who actually represent potential danger to themselves and to others. On the other hand, proper pliability of organization will permit the temporary care of such patients even in the general hospital.

There are few psychopathic states in which the patient is likely to harm others by attack. More often the patient is of greater danger to himself. Patients in epileptic and alcoholic delusional states as well as with paranoia and certain other types of hallucinosis may, through the mistaken idea of protecting themselves, strike down others. But a general hospital will rarely be requested to accept such patients.

More often physicians and nurses who have not had experience in handling the mentally ill deprecate the inherent danger. The nurse may ignore a comment by the patient that he does not wish to live longer. A physician may overlook the evident presence of hallucinatory fear on the patient's face. When such signs are observed, then is the time to act. To overlook them usually brings regret. It does and should not require a psychiatrist to sense suicidal intent.

Sometimes an epileptic is presented for admission. Often in the epileptic in the early stages or in the juvenile type before mental deterioration has progressed far the decision as to admission to a ward must be based largely on the need for sparing other patients the terror caused by viewing an epileptic seizure. Nothing so disturbs a general medical or surgical ward as does the sudden and unenpected development of a grand mal seizure on the part of one of its occupants. Generally it is not a good plan to admit other than the minor or petit mal epileptic to the ward or at the most those who suffer major seizures at long intervals.

There should be a definite rule in regard to the admission of depressed cases. The hospital has a perfect right to insist, if such patients are admitted to private rooms, that the family provide twenty-four hour nursing service.

Mental symptoms often develop in patients who did not manifest such abnormalities when admitted. For these patients a special report form should be employed, preferably of a specific color or shape so as to attract attention easily. By using these forms the administrator receives prompt reports when abnormal mental symptoms are observed. Such reports are likely to create a consciousness of existing danger in the minds of the nursing and intern staff. Upon the receipt of such information a medical officer should visit the patient in question and give necessary orders for his treatment.

Talks to the entire nursing and intern staff once or twice a year, by a physician trained in the handling of mental disease will help to keep the hospital personnel informed as to methods of treating such patients.

When a staff physician sends in such a patient he should be held responsible for providing proper nursing service and also for removing the patient should his presence prove embarrassing to the hospital. Under proper conditions a general hospital may safely treat psychotic patients for some days or weeks without disturbing other patients.

Another problem frequently arises in the accident ward of the general hospital. Here patients who have made suicidal attempts are received for emergency care. These patients must receive treatment for gas or drug poisoning and they may have wounds that require surgical care. There are few more difficult situations for an administrator to meet than that of a patient who has leaped from some high place and has sustained multiple fractures of a major nature that require general hospital care over a long period of time.

This is particularly true if the patient is a ward patient and if for some reason there is not a government hospital near by which will receive him. Many such hospitals object to accepting patients who have received injuries until their surgical condition has been remedied. This may mean that a general hospital will be required to care for a psychopathic patient with marked suicidal tendencies over weeks or even months. A hospital that is enterprising enough to care for an unexpected contagious disease patient, for example, also will develop methods of preventing further suicidal attempts by a psychopathic patient.

When a general hospital patient develops marked symptoms of mental illness, responsible members of the family should be summoned and

the medical officer of the institution should discuss this problem with them. It is not fair to demand removal without endeavoring through the director of social service to assist the family in making plans for the proper future care of the patient. In instances in which the patient may not be removed promptly to a psychopathic hospital, *e.g.* when he has a prolonged physical illness like typhoid, the family should be notified of the danger and be required to share responsibility with the hospital. The family doctor should share this responsibility and should be required to assist in making plans for the care of the patient after discharge.

Every general hospital should provide screens for window protection which are secure yet unostentatious. In instances in which a psychopathic patient has leaped from the window of a private room in a multi-storied building, this accident often could have been prevented if window screens had been properly and promptly put in place upon the admission of the patient. To be sure, such patients should not be shocked by having screens noisily applied in their presence. Such a procedure is likely to make the patient feel that he is being locked up in a jail.

Uses Few Restraint Measures

The next precaution to be taken is the application of some type of restraint to the patient. One sees the clumsiest, most cumbersome and ineffective efforts at restraints made by interns and nurses trained in the general hospital. In many general hospitals, the administrator has failed to provide proper restraint apparatus. When twenty-four hour nursing is available, often little, if any, mechanical restraint is needed.

One may almost surely detect by the attitude of the nurse or doctor toward a disturbed patient whether he or she has been trained in the handling of mental illness. A nurse who permits her facial expression to register amusement in the presence of the mental patient or who considers hallucinations and delusions as ludicrous should never be permitted to serve. For such patients a sympathetic attitude, in which the nurse agrees with delusional or hallucinatory statements, is much less likely to bring about the necessity of physical control than is the manifestation of an antagonistic attitude. For example, an alcoholic delusional patient fears he will be harmed by the dread apparitions that surround his bed. A skilled nurse may do much to reassure such a patient.

Physical restraint may be of several types. A senile confused state requires little more than side gates and proper chest sheet restraint. A more active patient may require muslin restraint bands applied to wrists and ankles. The nursing school should include in its course practical demonstrations of the methods of applying restraint. These can best be given by a nurse trained in a psychopathic hospital. Leather cuffs and anklets are harsh and cruel in appearance and need be but rarely used. The old-fashioned strait-jacket, except for the most violent patient, has fortunately disappeared from the armamentarium of both the psychopathic and the general hospital.

Many hospital staffs, both visiting and intern, are inclined to adopt drug restraint too frequently. Patients have lost their lives because someone has administered a large dose of morphine to control physical activity. Indeed, in such a condition as pneumonia with an active delirium drug therapy is crude and inexcusable. An inviolable rule should exist which forbids interns from prescribing such medication.

Hot and cold packs may be given in a hospital ward bed; these provide not only therapeutic sedation but also apply restraint at the same time. Too rarely do ward physicians order such life-saving treatment. To restrain a bed patient who is suffering with a toxic delirium by the use of crude leather cuffs and anklets or even with muslin restraint bands without endeavoring at the same time to use hydrotherapy often means losing a life when one might be saved.

A patient in restraint requires careful attention by nurse and doctor as to bowels and bladder and care must also be taken to prevent chafing and bed sores. In some institutions the physical therapy department supplies the highly practical continuous bath. Here excited patients may be kept immersed in water of a sedative temperature for many hours or even days. The patient's chances of recovery are greatly enhanced by such treatment.

Many physical conditions manifest delirium at some time during their course. Nightfall often brings on delirium and at this time the skilled nurse and physician are on the lookout for patients who may get out of bed or rush precipitously down stairways. Proper nursing should supply relief at meal time for such a patient. In typhoid fever and pneumonia, an unwatched delirium which results in a patient leaving his bed has too often resulted in an unfavorable outcome. In uremic coma the patient is less likely to endeavor to leave the hospital.

When to Call a Conference

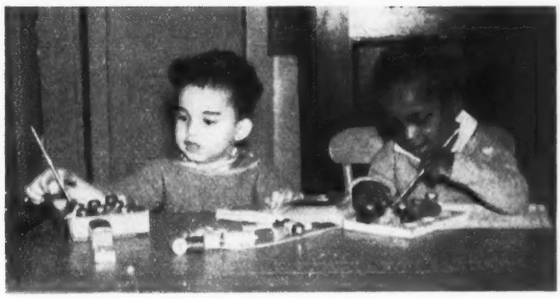
Should a catastrophe occur and a life be lost, it is the duty of the hospital administrator to call a conference of all those concerned to take testimony as to the time of development of the psychosis, as to the symptoms manifested and as to the precautions taken. The executive should assume that somehow some one of those present could have prevented the accident. This conference is likely to leave a life-long impression on the minds of the nurses and doctors who came in contact with the unfortunate patient.

No one should make light of the fact that the patient, even though likely to face a life of chronic mental illness, should be any less carefully protected than an acutely delirious patient who is likely to recover eventually. In other words, because a paranoic, recognizedly incurable, lost his life in the general hospital, no one should evade responsibility by being permitted to think that perhaps the accident was best after all.

In concluding the executive may then point to lessons that are to be learned from the incident. There are seasoned executives who appear to believe that such accidents come in threes. Probably this is a mere superstition but all should be on the alert at all times for possibilities of danger and each must personally believe that it only requires the right combination of circumstances for the most devastating occurrences to take place in the best and most efficiently conducted general institution.

Occupational Therapy Modernized

MARY E. MERRITT



Painting improves both grasping and coordination.

THE benefit of occupational therapy in giving diversion to the sick and injured and its assistance in preventing compensation and traumatic reactions need no defense. The unquestionable results and ready expansion of this application of occupational therapy speak for themselves.

The great impetus occupational therapy received during the war years seemed to be losing its momentum in a number of the municipal institutions and it became clear that some of the original methods of occupational therapy were not in keeping with advanced hospital procedures.

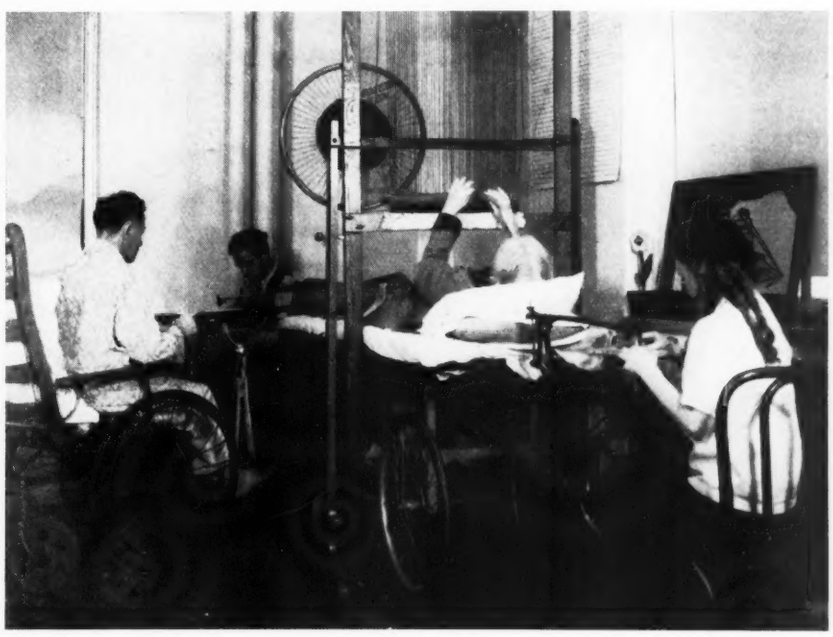
One of the original practices was the production of colorful, artistic handicrafts which were equally dazzling to the public and medical staff. Such articles invariably necessitated elaborate preparation and finishing by the occupational therapist. This, in turn, limited the number of patients she was able to reach. If she ceased the preparation and finishing to care for more patients, her clientele assumed that her work was deteriorating and that she was no longer as efficient.

During the war many soldiers were frequently without pay for months and the practice of reimbursing patients for work done was established. This second "hand-me-down" was in rather general use; it was, and still is, a serious and deeply rooted delusion. The system of payment varies, but the ultimate result is the same. One policy permits the patient to make two or three articles of equal value, one of which is given to the patient to dispose of as he pleases. The remainder are sold, the proceeds going to reimburse the department for materials used. Another practice is to have each article sold by the occupational therapy department and after the cost of the material is deducted, the profit is given to the patient. A third arrangement is to sell the material outright to the patient, assist him in designing and making the article and in finding a customer.

At best the patient receives little money and he becomes anxious to earn more and more. To meet his growing enthusiasm, orders are taken for articles, the whole program becomes increasingly commercial and the benefit to the patient, exceedingly questionable. The most serious result is that it is impossible to keep any medical reports or satisfactorily to contact new patients when finances are demanding.

If occupational therapy had been of value in the hospital with the foregoing complications, it was believed that it could be of untold assistance if placed under complete medical supervision and used as a specific therapy. The following reorganization was initiated in the Department of Hospitals, New York City, with first attention given to general hospitals.

Occupations were listed and regarded as graduated exercises. Each department was equipped so that this would be possible. Every effort



Occupations that induce voluntary motion. The wheel chair patient uses a tricycle saw for flexion and extension of the knee; the stretcher patient weaves on a frame for flexion and extension of elbows and shoulders, and the chair patient uses a treadle saw for flexion and extension of ankle.

Weaving on this loom permits flexion and extension of the elbows and also assists in developing the muscles of the thighs and legs for weight bearing.

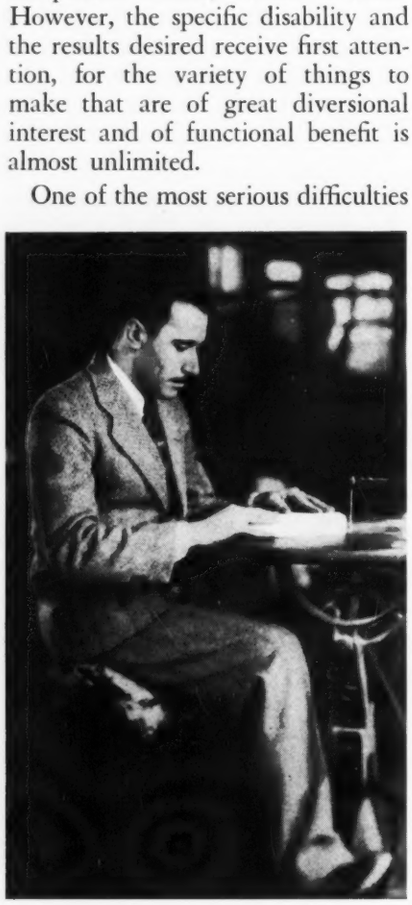
was directed toward improving the patients' physical and mental condition. Work and occupations were given to induce voluntary motion rather than to impose activity.

Only the simplest tools, materials and equipment were installed for use. All cumbersome technic was eliminated. There were no alterations in equipment to meet physical disabilities; for example, if a patient could not close his hand, the handle of a tool was not built up for him to grasp. Instead, he was given a tool he could hold and a handicraft that necessitated the constant picking up and laying down of that tool. For example, block printing induces flexion and extension of the fingers by using the hammer and roller. The winding or unwinding of a ball of wool in preparation for rug making also gives flexion and extension to the fingers.

For most knee disabilities, a seatless bicycle saw and chairs of varying heights are used. The higher the chair and the farther away it is placed, the greater the extension of the knee. Conversely, the lower the chair and the closer it is placed to the saw, the greater the flexion of the knee. For increasing muscle strength the wood is varied from the thin to heavy and so on.

Occupations and materials are adapted for all joint and muscle functions. The incentive always is something to make that is of interest to the patient. It matters not whether the patient is man, woman or child. However, the specific disability and the results desired receive first attention, for the variety of things to make that are of great diversional interest and of functional benefit is almost unlimited.

One of the most serious difficulties has been to relay the personnel for training in this method of treating cases with motor difficulties. A student practice training course of six months, cooperating with the schools of occupational therapy, was established and suitable students have been placed in staff vacancies as they occur.



A patient uses a bicycle saw for flexion and extension of the hip.

To reeducate the patients and their relatives in regard to this revised program, new patients were told that the occupational therapy department was just the same as any other department of a hospital and strictly a treatment agency, except that other departments do not pay the patient for receiving treatment.

A prescription card was adopted which can be used universally, whether the patient is mental, tuberculous, medical or surgical. This card has these significant headings: name of patient and case number; date of admission to hospital; date referred to occupational therapy; date of discharge; diagnosis; mental or temperamental characteristics; previous vocation; conditions to be treated; results desired; warnings, suggestions and special instructions, and the signature of physician.

Occupational therapists were instructed as soon as practicable, to accept no new patients without such a card filled in and signed by the physician. This card eventually brought most doctors to the occupational therapy workroom or office to see what it was all about.

The doctor found that certain occupational therapy workers had acquired another vocabulary. They no longer talked paints, nails and cross-stitch but had acquired sufficient medical information to confer with him in regard to indicated treatment.

The physician frequently saw two large charts on the workshop walls; chart 1 showing the craft analyses and chart 2, a diagram illustrating the recording of joint measurements.

A simple homemade arthrometer which was accurately recording the progress of his patients was demonstrated. The doctor also found that progress charts of each patient were on file. These charts were kept in the occupational therapy temporarily in order to compile statistics, to determine exactly the number of treat-

ments, the period of time certain cases received occupational therapy and the results obtained.

An analysis of processes necessary for the construction of certain articles made for institutional use with the accompanying muscular and joint functions involved is now under way, with the idea of using them in addition to handicrafts, merely to increase the scope of occupational therapy activities. The winder, a machine used in broom making, has a revolving foot piece that gives certain beneficial movements for ankle, knee and hip; incidentally, the weaving of turkish towels and bath mats in color is just as intriguing and uses the same joints and muscles as the weaving of anything else.

There are certain patients who frequently choose to make things for the hospital in return for the free care given them. There are many utilitarian articles that are of great therapeutic value, provided the occupational therapy department does not expect the patients to meet institutional demands.

The "modernizing" of the occupational therapy division is being gradually developed in order not unduly to disturb the regular routine or procedures of the several institutions. Patients graduate from ward to shop. Hospital patients report daily for occupational therapy; out-patients report on alternate days.

Only two persons were added to the personnel service and yet results of this first year show a great increase in the patient census for the division; one completely reorganized division has increased 250 per cent. Patients are just as contented as previously and many have expressed gratitude for improved health. This occurred only rarely before the new program was instituted.

Articles constructed for institutional use increased from 33,912 to 150,628, and occupational therapy articles from the 5696, previously reported, to 19,934. Nearly all occupational therapy articles were sold and the proceeds paid for materials.

The physicians themselves, judging from the increasing number of patients they have referred, and their requests for occupational therapists on services we have been unable to reach, are pleased with the results.

When the complete occupational therapy program is in effect, in addition, there should be vocational guidance so that the department may serve as a rehabilitation agency while the patient is still hospitalized. If the patient is assisted in understanding his own mental and physical capabilities, he will not become a charge in a public institution. We intend further to correlate our activities, under medical supervision, with the other treatments given to individuals. We are sure that occupational therapy will gain tremendously in the future.

For Contented Nurses

J. WINIFRED SMITH, R.N.

ARE the general duty nurse's discontent and restlessness due merely to the question of wages and hours? Could she be made happier and more contented? Does she sometimes feel she is the step-child of the hospital? Have we really made her the step-child or the least favored member of the institutional family?

She sees house mothers, social directors and training school personnel mothering the nurse in training, providing for her recreation, guarding her health and welfare, providing her with educational opportunities. She sees attractive quarters assigned to the supervising staff. She sees the most attractive single rooms offered to prospective students in the school. Whatever is left is assigned to her. She is hired to fill the gaps.

Can't we do something for her psychologically? Perhaps the purse strings can be persuaded to open a bit to improve her living conditions if it is pointed out that this will bring cash returns in efficiency, morale and stability of nursing service.

Probably some kind of living or reception room has been provided for her. Is it ever used? Does it need some fundamental change in situation to make it usable as a place to entertain her male friends? Or is it merely a gray and shabby room?

Perhaps a set of curtains or new slip covers for the furniture will make it a different place. The local decorator may be consulted as to the cost of creating a cheerful and homelike atmosphere. Sunny colors, pink geraniums or begonias in pretty pots and a singing canary or two will help. If there are any magazines, let them be new and popular ones.

The housekeeper in charge can make her feel that the home is for her use and pleasure. She is not a student in whom the school is trying to instill habits of orderliness and neatness. She should be permitted to live comfortably without nagging and made to feel that she belongs to the home and that it is her home. Some provision for cooking an occasional meal will be appreciated. A few bright pans and dishes cost little.

In case of illness the general duty nurse should be encouraged to report or send word to the training school office where someone should have time to give her sympathetic attention and see that she has medical service, adequate nursing attention and whatever she needs from the dietary department.

The general duty nurse should be given the opportunity to take some course for professional advancement, but nothing is accomplished by trying to force it down her throat. It should be offered if she wants it and feels she can afford the expense. On pay day opportunity can be laid directly in her path to save something of her salary.

Above all, someone in the training school office should have the time to talk over her problems, plans and complaints with her. She appreciates any interest shown in her welfare and advancement and also an occasional bit of mothering even more perhaps than the student who receives it more freely.

Why not give her what is possible in the way of human values as well as in money and hours? Why not try to make her feel that her welfare means just as much to the hospital as that of the rest of the family?

More Paint, Less Maintenance

JACOB GOODFRIEND

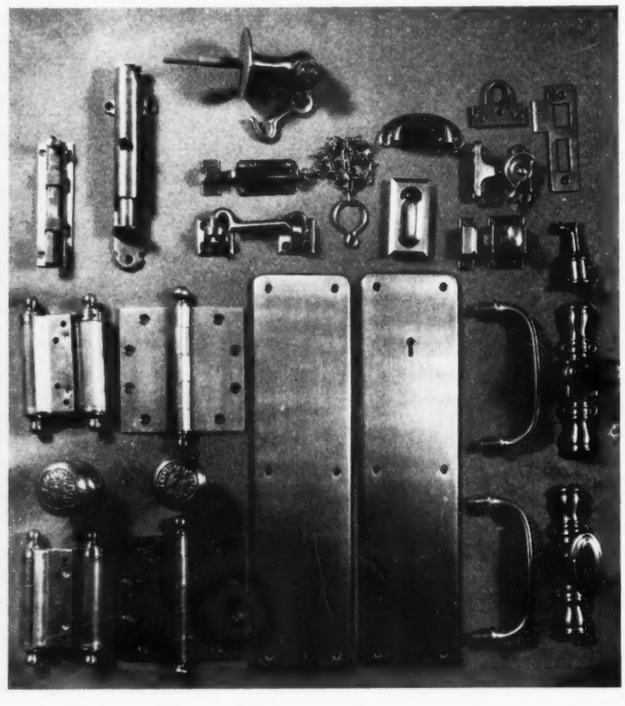
WHEN the problem of selecting the proper grade and type of paint for a particular purpose in the hospital arises, the administrator does well to seek the advice of the paint manufacturer, who has a staff of technical experts at his command.

Coloring and mixing of paint can be done more accurately by the paint manufacturer than by the painter at the institution. At the paint factory, batch after batch can be turned out without the slightest deviation in color, while this is practically impossible in the hospital.

The same type and grade of paint cannot be used for exterior, interior, concrete and metals. We know that paints are manufactured and specifically designed for each of these particular purposes. The reliable paint manufacturer will gladly furnish such information regarding his paints and even supply sample cans of paint for experimental purposes. It is useful for the hospital administrator to know, for example, that a black paint, which is a ground color, will often last twice as long on outside fences as a green or gray paint. Patching and repainting are more easily done over black, entirely eliminating the use of red lead, if done before deterioration and peeling begin. It also has better hiding power than any other color. Outside window trim and fire escapes can be painted black effectively if the color harmonizes with the general color scheme. One becomes accustomed to black in a comparatively short time and the economy to a philanthropic institution is not negligible.

At Montefiore Hospital, New York, we adopted a general color scheme for interior painting, choosing a soft ivory or light cream color to replace the gloomy battleship gray formerly used. The color is properly shaded to blend into the surroundings. We find that patching is more easily done when the color scheme throughout the buildings is more or less the same. Rooms that are poorly lighted are treated with the lighter shades. A dado line, in a light brown shade placed at a height of 5 feet, is used in the rooms and corridors.

A number of other suggestions have proved both practicable and economical. For example, after a careful study we found that the polishing of brass and other bright metals, such as fire extinguishers, kick plates, door fittings, electric fixtures and the like, consumed a great deal of porters' time and proved a tax on the budget. We also found that in some instances the metal polish would corrode the structure to which the metal was attached, such as a fire hose. We found that by painting, oxidizing or plating this equipment, we were able to reduce the maintenance cost and add to its appearance without affecting its efficiency. The metal car of an ele-



Left: Fire escapes painted black are less conspicuous against the red brick of the building. Below: Brass fixtures are oxidized and do not require polishing.

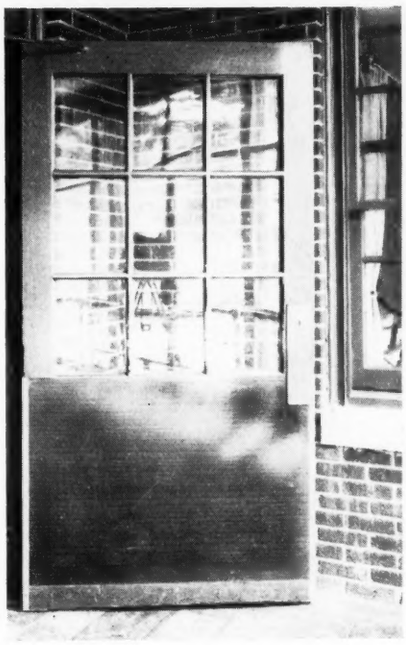
vator, if unattractive, can be redecorated in a cheerful color with a paint spraying machine.

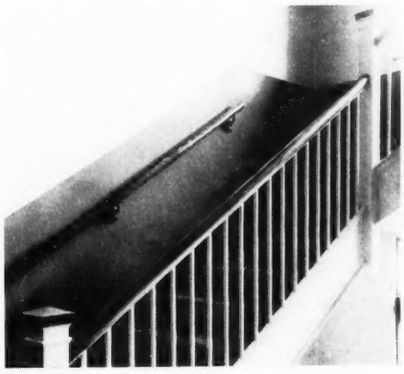
When direction signs are lettered on corridor walls it is advisable to use a colored border around the lettering; in fact, the lettering might be done on a colored patch, so that when painting is found necessary in such locations the lettering may remain intact. Yellow lettering shaded in black is effective on a mahogany background; white lettering has been found to be satisfactory on oak doors and panels in dull locations.

We have found it more economical to engage a sign painter for short periods during the year than to have the work done by an outside contractor. It is essential, however, that his work be supervised carefully. Thus we are able at little expense to identify wheel chairs, stretchers and other furniture, ice bags, hot water bottles, invalid cushions and enamelware for each ward.

Electric panel plates, which measure a square foot or more and are usually painted the color of the wall, can be made to match the wood or metal work of the window and door trim in their respective locations. Electricians and other mechanics who use these panels frequently, leave finger marks on the doors and these soon present an unsightly appearance. For the protection of painted walls, all laundry trucks, food trucks, stretchers and wheel chairs should be equipped with rubber bumpers. Rubber projections should be placed on the legs of beds. As a protection against the careless handling of heavy trucks, corners of walls can be reenforced with angleiron imbedded into the wall, leaving a smooth surface. Wooden doors that are subjected to hard use, such as pantry and lavatory doors, may have a section of battleship linoleum, sheet rubber, durable composition or other material in a color to harmonize with that of the doors fitted into the bottom panel. Frequent bumping into these doors with trucks or wheel chairs dents and scratches the surface, causing damage difficult to repair.

At Montefiore Hospital we have adopted a light brown color for beds, chairs and bedside tables with a measure of success. We have learned that one cannot please everybody with any particular color scheme. In





Above: A linoleum panel at the bottom of this door serves as a kick plate and also absorbs bumps from trucks. Below: The staircase is painted light cream and brown.

former years beds were painted a light ivory or cream color. When the paint chipped, the contrast in color between the bare metal and the light finish presented an unsightly appearance. With the selection of brown for the purpose, this condition was materially improved. It is important, however, completely to remove all paint down to the metal when changing to a darker shade.

The adoption of rubber tops for bedside tables has made it unnecessary to paint these tables frequently and has eliminated noise. The appearance of the wards also was considerably improved. Black slate toilet partitions can be refinished to resemble grained marble, giving an appearance of cleanliness. We try to preserve the original color of furniture and woodwork, if at all possible. There is a tendency in hospitals to paint window trim, when frequently a coat of varnish is all that is required to restore the original surface. Necessary repairs should precede painting in order to avoid subsequent unsightly patching and dabbing.

Rooms in private pavilions may be painted when the census is low, in order not to inconvenience patients unnecessarily. There is no need for different color schemes in different rooms since patients do not change rooms. Offices and out-patient clinics can be painted over week ends or during extended holiday periods. This would also apply to the laundry and the linen rooms.

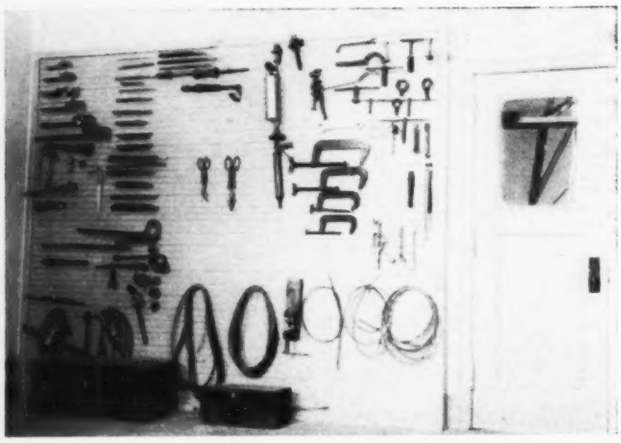
The most convenient time to paint dormitory rooms is during the summer months when a large number of employes are on vacation and their rooms are vacant. It is unfortunate that sick persons in the wards of the hospital must be subjected to the inconvenience of painting and the hardships of noise and odor that it entails. Every effort should be made, therefore, when painting the wards of the hospital, to use a grade of paint with good wearing qualities and one that will withstand frequent washings. There are paints the odor of which disappears in a comparatively short time. If the installation of tile walls in wards were practical, the problem could be solved permanently.

Inasmuch as the cost of labor in painting is approximately two or three times the cost of the material used, the difference in cost of doing a job with the best grades of paint is estimated at 5 to 8 per cent more, which is neutralized because of the possibility of substantial saving if the frequency of painting can be reduced.

Recently a new type of wall covering has been introduced into hospitals. It is an oil-paint-in-roll form, claimed by the manufacturers to give the protective value of six coats of paint. It is washable and fadeless and is furnished in many colors. The cost, it is said, is approximately the same as painting. The inconvenience of offensive paint odors is eliminated and the room can be used immediately after its application. Patching can be done without detection. It is said to have the sanitary features of paint and the decorative value of wallpaper, without the disadvantages of either.

A Place for Every Tool

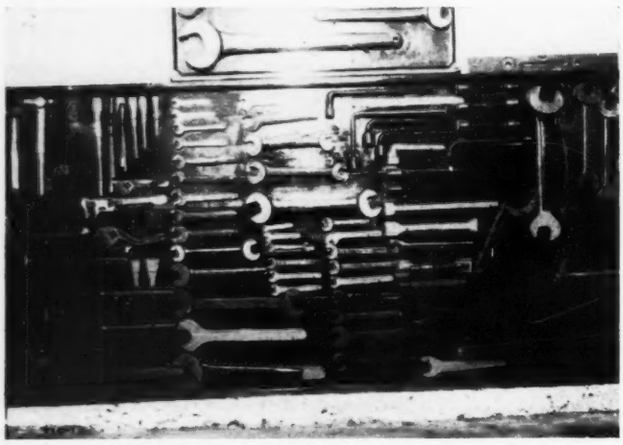
R. STARR PARKER



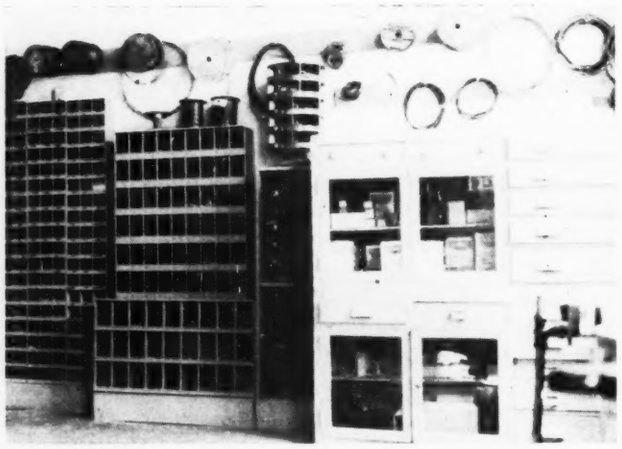
A tool board holds a portion of the maintenance tools most frequently used. It is mounted in a shop-room accessible to the mechanics but out of the path of passers-by. The mechanic checks it each evening.

THE organization of tool and supply stocks is a phase of maintenance work all too frequently neglected. Yet many repair jobs are "emergency" and demand instant access to the proper repair part and the proper tool with which to make the repair. At Christ Hospital, Cincinnati, we have developed a system whereby tools are returned or accounted for.

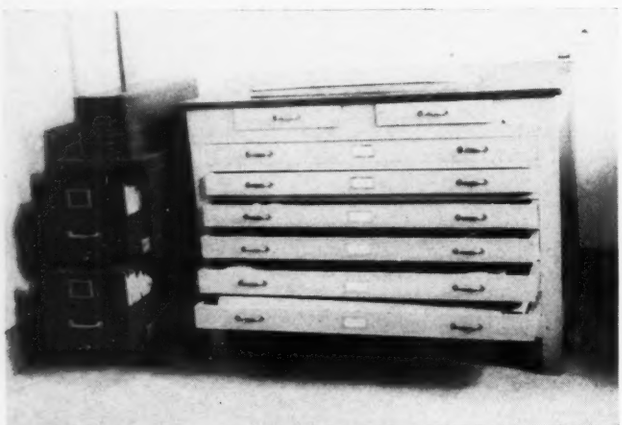
Nothing facilitates maintenance work quite so much as having ample repair necessities and proper tools in orderly arrangement. Nor is there anything more irritating to a good mechanic than to be forced to spend 15 cents worth of valuable time hunt-



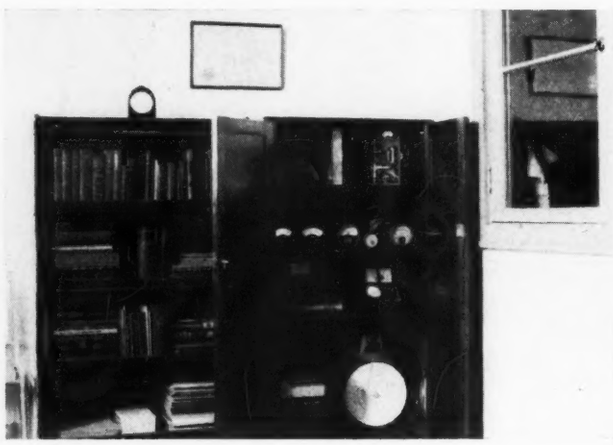
One of the engine room tool boards. This board is painted black and has the outline of the tool itself painted on it in red so that the engineer may see at a glance when any tool is off the board.



Small parts bins hold a portion of the hundreds of screws, nails, washers, nuts and the like. The cabinet at the right is used for storing electrical supplies and the shelves are for bulkier miscellaneous supplies.



Blue prints, records and catalogs, because they are often needed for reference, should receive special treatment. Various sizes of files make them available to the accounting department at all times.



Special testing equipment and delicate instruments should be stored with the value and sensitivity of this equipment in mind. A cabinet, like the one shown above, helps to keep them from getting lost.

BACKED BY THE EXPERIENCE OF A GOVERNMENT-LICENSED BIOLOGICAL LABORATORY!

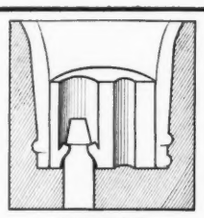
No law permits licensing of dextrose solutions. But prescribing "in Saftiflasks" gives you the benefit of the experience and skill gained in the production—and, more important, the *testing*—of products for intravenous injection according to the standards of a government-licensed biological laboratory.

Biological workers know that no product intended for intravenous injection is safe until it has been *proven* safe—by rigid laboratory checks.

At Cutter Laboratories dextrose solutions are tested as exactingly as biologicals. Tested chemically, biologically, physiologically—by a separate testing staff, which has been assuring the safety of Cutter products for over 40 years.

Because of large volume production and testing, these ready-prepared solutions are no more costly to patient or hospital than solutions prepared in the hospital. To avoid the reaction "bugbear," specify solutions *in Saftiflasks.* In two, one, and one half-liter sizes.

Cutter Laboratories, Berkeley, California and 111 N. Canal Street, Chicago.
(U. S. Government License No. 8)



SIMPLE

Only one part required!—A connecting tube which is supplied with each case of Saftiflasks . . . Patented soft rubber stopper fits any connection tube . . . Connection tube becomes integral part of your injection outfit. No loose parts to wash, sterilize, reassemble. No involved technique, with resultant multiple sterility hazards.

Electrometric determination of soluble alkalis in the glass parts of the Saftiflask set-up by means of the glass electrode.

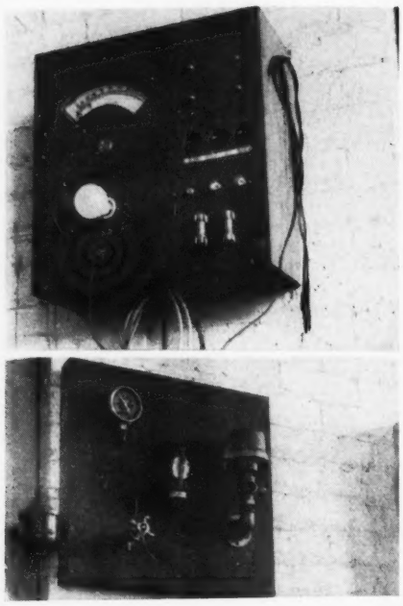
ACCEPTED
AMERICAN MEDICAL ASSN.
Council on Pharmacy and Chemistry

DEXTROSE SOLUTIONS IN

Saftiflasks

This cabinet, designed with many sizes of compartments and an abundance of shelf space, holds department repair parts of all types, plumbing repair parts, casters and heating system supplies, each in its allotted space.

A special panel, constructed for testing dictographs. The complete nurses' call circuit is represented on the panel so that 90 per cent of all dictograph troubles can be corrected in the shop without disturbing the patient unnecessarily.



The test panel at the top permits volt meter tests on different types of electrical equipment and also is provided with three transformer taps. The panel below is for servicing equipment used for automatic control of room heaters.

ing for a 1 cent bolt or a misplaced tool.

The ideal arrangement is to have a central stockroom in charge of a stockkeeper. Few hospitals are large enough, however, or have the proper layout necessary to permit such an arrangement. In smaller shops it is usually satisfactory to put the supply stock under the care of one of the helpers and have the master mechanic or the mechanical supervisor check the stock frequently. The principal consideration is to have a place for everything and to have everything in its place. Valuable pieces of equipment should be kept under lock and key.

None of the items shown represented any great outlay of money. The panels were constructed of salvaged materials; some kitchen cabinets were reconditioned and adapted to their present use; the parts bins were procurred from a salvage company; the blue print cabinet constructed by the carpenter, and the instrument cabinet made from an old bookcase.

Nor was the work done in one fell swoop; rather, it represents the gradual efforts of the mechanics during slack periods over a year's time.

Fire-Resistant Wood Doors

FIRE-RESISTANT wood doors may be constructed of solid wood which has been processed to resist fire or of panels constructed with an asbestos filler in the dead air spaces between, according to specifications prepared for the 17th HOSPITAL YEARBOOK.

In the latter type, the dead air space should be completely filled with sheet asbestos three-fourths of an inch thick to make an effective barrier to the passage of fire. Doors of this type should be able to resist heat of 1700° F. for sixty minutes.

The wood materials used should be treated with chemicals whose functions are threefold: to give off, when heated, a noninflammable, fire-extinguishing gas or vapor; to fuse over the wood in a protective coating, and to exclude the oxygen necessary to combustion by obstructing the pores of the wood. Each of the pores of the processed wood ought to be a diminutive fire extinguisher, exuding noninflammable gas or vapor when heated. The larger the surface used, the more effective should be this property. Wood processed by standard methods should take shellac, paint and varnish well and the efficiency of the glue joints should not be lessened.

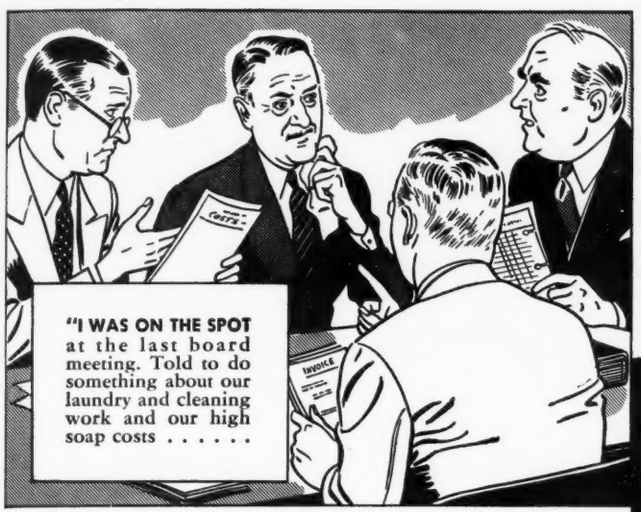
All lumber and core material to be treated for fire-resistant qualities is first kiln-dried and then placed in a steel cylinder. The cylinder is then closed, the air exhausted and the interior of the cylinder kept under a vacuum for several hours. The fireproofing solution is then admitted to the cylinder and forced into the cells of the wood under pressure until the wood is thoroughly impregnated.

The material is removed from the cylinder and subjected to air-drying for two or three weeks and then placed in dry kilns for four or five weeks, depending upon the thickness and texture of the lumber to be dried. Items of veneer up to one-quarter inch thick can be fireproofed and kiln-dried in three weeks.

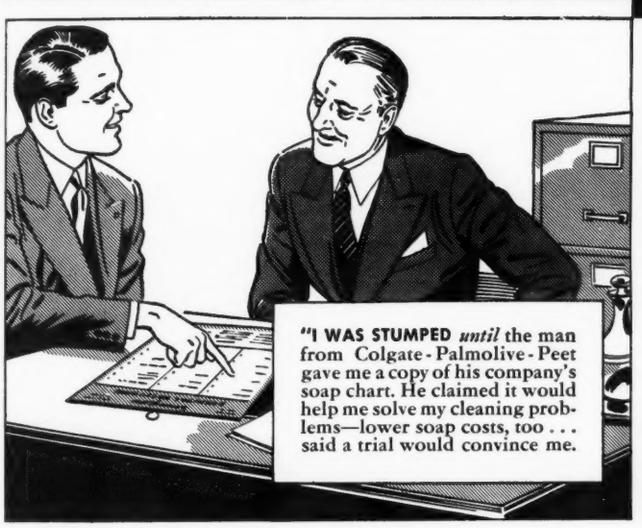
Three standard tests, known as the "timber test," the "crib test" and the "shaving test," are used to determine fire resistance of doors.

WHAT A SWELL REPORT I'VE GOT FOR THE NEXT BOARD MEETING!

THANKS TO THIS FREE HOSPITAL SOAP CHART



"I WAS ON THE SPOT at the last board meeting. Told to do something about our laundry and cleaning work and our high soap costs . . . . . .



"I WAS STUMPED *until* the man from Colgate-Palmolive-Peet gave me a copy of his company's soap chart. He claimed it would help me solve my cleaning problems—lower soap costs, too . . . said a trial would convince me.

"HE SURE WAS RIGHT! This C.P.P. soap chart saves money, labor and materials. It helped me simplify cleaning jobs . . . pick the *right* soap for every use . . . cut soap inventory to six classes, I can hardly wait to give my next report."

GET YOUR FREE COPY OF THIS ACCURATE SOAP CHART TODAY!

ASK your C.P.P. representative for the simplified Hospital Cleanliness Chart . . . and booklet, "Hospital Cleanliness," containing information on latest cleaning methods. Or, write us for *free* copies.

Colgate-Palmolive-Peet has the right soaps for every cleaning need. And remember, you can do *more* laundry work . . . clean *more* surfaces *better* with C.P.P. Soaps than with so-called "bargain" soaps.

Your C.P.P. representative will gladly give you full information on these *better* soaps.

COLGATE-PALMOLIVE-PEET COMPANY

INDUSTRIAL DEPT., Jersey City, N. J.

Permanent Inventory for Linen

MARIE T. NEHER

EVERY housekeeper's ideal is a system of linen control that is permanent and reasonably accurate and that does not require excessive time for bookkeeping.

At the University of Chicago Clinics we have a central linen room system and a perpetual stock card setup that serve as a check and a balance for each other and they make it possible for the housekeeper to determine the hospital stock of linen at any time. Simplicity of operation is one of the outstanding features. Two types of stock cards are used, blue cards for ready made articles and white for yard goods. As linen is issued to the various divisions of the clinics it is charged off against the department in which it will be used and the amount is deducted from the card. As purchases of new linen are made the items are entered by number and date on the proper card.

Purchases, including linens, employe's uniforms and the like, are made by the housekeeper by requisition through the purchasing department of the University of Chicago. In the purchasing department are assembled and coordinated all orders received from all the buildings of the university. Purchases are then made from selected manufacturers.

It is our policy to buy standard lines of goods so that replenishments can be made at any time without running the risk of finding that a particular line no longer is being manufactured. If any change in quality or workmanship or design is made, the manufacturer is required to submit a sample, which is then considered by both the purchasing agent and the housekeeper. The first purchase made from a new source and any new type of merchandise are carefully checked as to workmanship and quality against our stock merchandise. In the event of a complaint of variance in quality or other specifications, the manufacturer is communicated with and an adjustment is requested.

Purchases of linen are passed through to the central stock room where the item is entered on a stock card, together with the date of purchase, the order number, the name of the firm from which it was purchased, the amount ordered and the unit price. On the reverse side of this card are spaces for carrying forward the inventory. The stock balances, as shown on these cards, are verified by making an actual count of all articles in the stock room. An inventory of this stock is taken twice a year.

All linen that is put into service is requisitioned from the linen stock room and is passed on to the central linen room. Into the central linen room also come orders from various supplementary departments such as physiotherapy, metabolism, electrocardiograph, brace shop, health

THE UNIVERSITY OF CHICAGO
UNIVERSITY CLINICS
950 EAST 59TH STREET

LINEN LIST

No.	ARTICLES	No.	ARTICLES
	Aprons, Kitchen		Doilies
	Bags, Coffee		Holders, Stove
	Clothes		Gowns, Doctor's O. R.
	Drainage Bottle		Isolation
	Hat		Patients
	Laundry		Morgue
	Mending		Masks
	Mesh		Mats, Bath
	Protoclysis		Men's Drawers
	Slipper		Pajama Coats
	Binders, Breast		" Trousers
	Scultetus		Socks
	Surgical		Undershirts
	T Double		Mop Hoods
	T Single		Napkins
	Blankets, Bath		Napkins, P. P.
	Bed		" Staff
	Chair		Nightingales
	Children's Bath		Pillow Cases, Large
	" Bed		" " Small
	Children's, Bath Robes		Pads, Bed, Large
	Diapers		" " Small
	Gowns		" Hampton
	Stockings		Rags
	Vests		Robes, Bath
	Cloth, Steamer		Runner, Table
	Stove		Rugs, Rugs
	Table		Scarfs, Dresser
	Wash		Sheets, Draw
	Covers, Bed Pan		Children's
	Blankets		Large
	Chair		Treatment
	Couch		Morgue
	Denim, Bed		Slings
	Electric Heaters		Spreads
	Floor Brush		" Children
	Hot Water Bottle, Long		Squares, Table
	Hot Water Bottle, Short		Towels, Bath, Large
	Ice Cap		" Small
	Iron Board		Dish
	Machine		Dressing
	Mattress		Face, Linen
	Radiator Cover		" Cotton
	Rubber Ring		Glass
	Tray, Large		Side
	Tray, Small		Utility
	Truck, White Canvas		Women's, Drawers
	Truck, Brown Canvas		Princess Slips
	Curtains, Serim		Stockings
	Shower		Vests
	Mesha Cloth, Large		Wringers, Scupe
	" " Medium		
	" " Small		

TOTAL NO. POUNDS

Above is one of the many different linen lists used at the University of Chicago Clinics. The daily linen requisition is made out each morning by the head nurse on the floor. It is then checked by the superintendent of nurses before going to the linen room to be filled. The person who fills the order signs his name as does the attendant on the floor who receives it.

The University of Chicago
University Clinics

DAILY LINEN REQUISITION

NUMBER OF PATIENTS: 22 DATE 7-8-'38 DIVISION Private

ARTICLES	SHELF	REQ.	ISSUED	ARTICLES	SHELF	REQ.	ISSUED
Bags, Clothes				Masks, Two-thickness			
Drainage				Four-thickness			
Drum				Mats, Bath			
Hat				Men's Pajama Coats	15	6	6✓
Laundry	3	1	1✓	" Trousers	16	11	11✓
Mesh				Socks	25	50	50✓
Mending				Napkins			
Muslin large				Nightingales	5	30	30✓
" small				Pillow Cases, large	9	30	30✓
Protoclysis				" " small			
Slipper				Pads, Abdominal, large			
Belts				" medium			
Binders, Scultetus				" small			
Surgical				Bed, small			
T. Double				Brain			
T. Single				Table			
Blankets, Bath	6	10	10✓	Rags	0	40	40✓
Bed				Robes			
Chair				Scarfs, Dresser Fancy 10 Chair		10	20
Capes, Visitors				Sheets, Draw	0	35	35✓
Caps, Doctors	10	15	15✓	Eye			
Nurses				Lap			
Cloths, Wash	5	30	30✓	Large	0	35	35✓
Coats, Doctors				Treatment	2	10	10✓
Covers, Bed Pan	0	30	30✓	Morgue			
Chair				Sleeves, Stockinet			
Couch				Slings			
Electric Heaters				Spreads			
Floor Brush	0	3	3✓	Stockings, Ether	0	3	3✓
Hawley, large				Women's			
" small				Towels, Absorbent			
Head Rest				Bath, large	3	30	30✓
Hot Water Bottle, long				" small			
" " " short				Dressing	0	15	15✓
Ice Cap				Face, linen	0	30	30✓
Instrument Tray				" cotton			
Mattress	1	3	3	Glass			
Rubber Ring				Glove			
Sand Bag				Trousers, Doctors G.O.R.			
Tray, large	35	50	50✓	Wrappers, Glove			
" small	10	3	5✓	large			
Dresses, Nurses				medium			
Dusters, G.O.R.				small			
Holders, Stove				extra small			
Gowns, Doctors, G.O.R.				10X10			
Isolation				6X6			
Patients	0	15	15✓				
" Operating							
Morgue							
Lifters, Patients, G.O.R.							
Masks, Ether							
Gauze							

SOUND INSULATING *and* FIRE RESISTING PARTITIONS

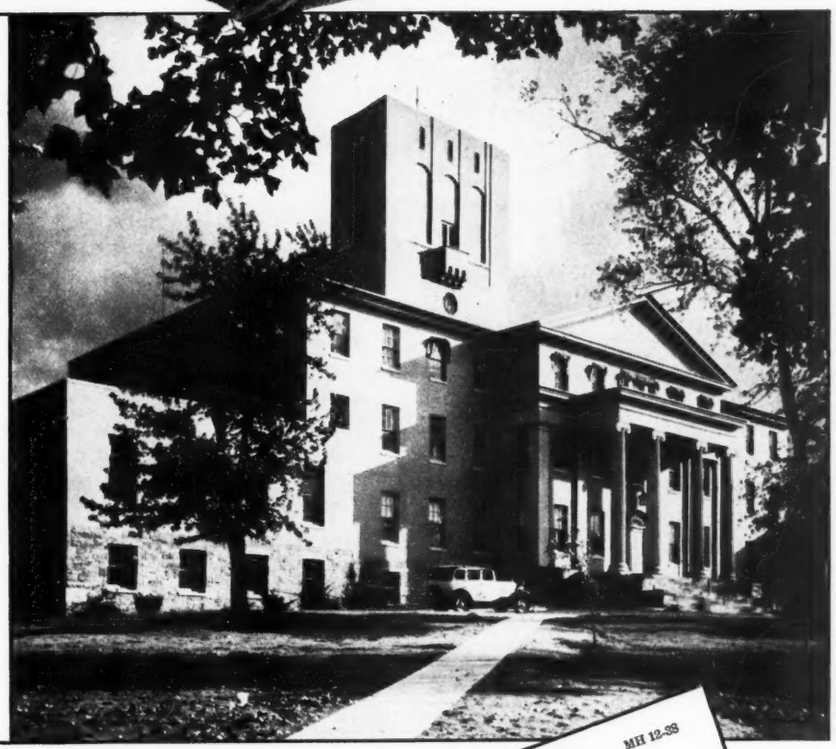
Assured for Washington County Hospital

WITH 136,000 FEET OF . . .

Sound-insulating partitions are of major importance in modern hospital construction. Patients must be safeguarded from the *disturbing effects of clamor* in adjoining rooms or corridors. That's why Buckler and Finhagen, architects for the Washington County Hospital at Hagerstown, Md., specified Thermax for sound-insulating partitions and furring . . . 136,000 feet of it! At the same time they gained definite fire protection and an excellent plaster base —*all at one cost!*

This hospital is only one of many which have utilized *the 3-way efficiency of Thermax.* The large rigid slabs, made of clean shredded fibres coated and bound with fire-resistant cement, are equally well suited for partitions, ceilings, roof decks, furring, and plaster base.

Thermax is widely used in fireproof construction, *and has the approval of building departments* in leading cities of the United States and Europe; classified by Underwriters' Laboratories, Inc. Use the coupon to get complete information.

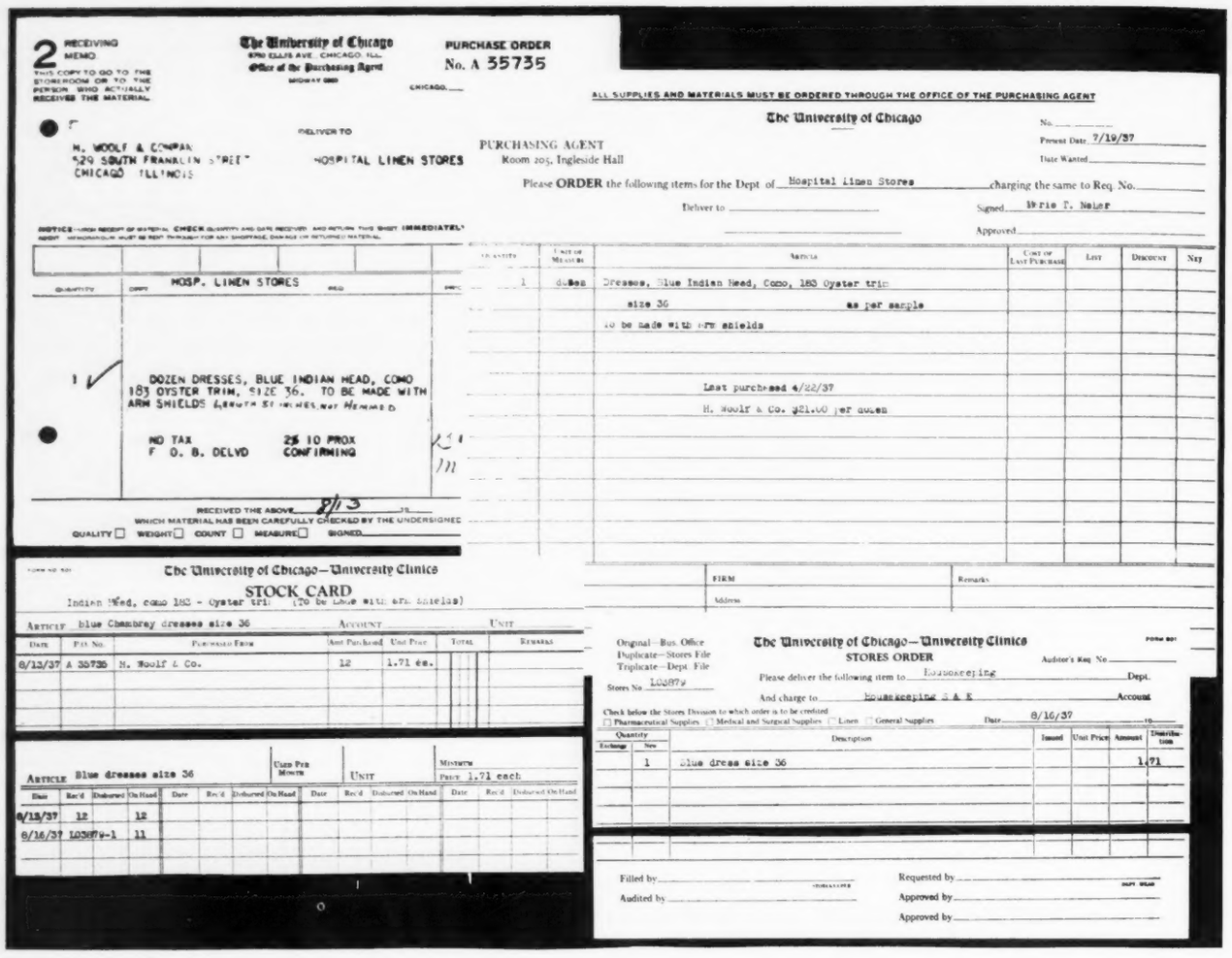


THERMAX
REG. U. S. PAT. OFF.
STRUCTURAL INSULATING SLAB BY

CELOTEX
REG. U. S. PAT. OFF.
World's Largest Manufacturer of Structural Insulation

THE CELOTEX CORPORATION MH 12-38
919 N. Michigan Ave., Chicago, Ill.
Please send complete information on Thermax, the fire-resistant insulation by Celotex.

Name.....
Address.....
City.....*State*.....
County.....


2 RECEIVING MEMO
THIS COPY TO GO TO THE STOREROOM OR TO THE PERSON WHO ACTUALLY RECEIVES THE MATERIAL

The University of Chicago
Office of the Purchasing Agent
CHICAGO

PURCHASE ORDER
No. A 35735

ALL SUPPLIES AND MATERIALS MUST BE ORDERED THROUGH THE OFFICE OF THE PURCHASING AGENT

DELIVER TO
H. WOOLF & COMPAN
529 SOUTH FRANKLIN STREET
CHICAGO ILLINOIS
HOSPITAL LINEN STORES

The University of Chicago
PURCHASING AGENT
Room 205, Ingleside Hall

No.
Present Date 7/19/37
Date Wanted
Please ORDER the following items for the Dept of Hospital Linen Stores charging the same to Req. No.
Deliver to
Signed Wm T. Neiser
Approved

NOTICE—UPON RECEIPT OF MATERIAL CHECK QUANTITY AND DATE RECEIVED AND RETURN THIS SHEET IMMEDIATELY

QUANTITY	DEPT	REQ	PRICE
	HOSP. LINEN STORES		
1 ✓	DOZEN DRESSES, BLUE INDIAN HEAD, COMO 183 OYSTER TRIM, SIZE 36. TO BE MADE WITH ARM SHIELDS (Length 31 inches, not Hemmed)		
	NO TAX F. O. B. DELVD	2% 10 PROX CONFIRMING	

RECEIVED THE ABOVE 8/13 19
WHICH MATERIAL HAS BEEN CAREFULLY CHECKED BY THE UNDERSIGNED
QUALITY ☐ WEIGHT ☐ COUNT ☐ MEASURE ☐ SIGNED

QUANTITY	UNIT OF MEASURE	ARTICLE	COST OF LAST PURCHASE	LIST	DISCOUNT	NET
1	dozen	Dresses, Blue Indian Head, Como, 183 Oyster trim				
		size 36 as per sample				
		to be made with arm shields				
		Last purchased 4/22/37				
		H. Woolf & Co. $21.00 per dozen				

The University of Chicago—University Clinics
STOCK CARD
Indian Hed, como 183 - Oyster trl. (To be Lave with arm shields)

ARTICLE Blue Chambrey dresses size 36 ACCOUNT UNIT

DATE	P.O. NO.	PURCHASED FROM	AMT PURCHASED	UNIT PRICE	TOTAL	REMARKS
6/13/37	A 35735	H. Woolf & Co.	12	1.71 ea.		

ARTICLE Blue dresses size 36 USED PER MONTH UNIT MINIMUM PRICE 1.71 each

Date	Rec'd	Disbursed	On Hand	Date	Rec'd	Disbursed	On Hand	Date	Rec'd	Disbursed	On Hand	Date	Rec'd	Disbursed	On Hand
6/13/37	12		12												
6/16/37	L03879-1		11												

FIRM
Address
Remarks

Original—Bus. Office
Duplicate—Stores File
Triplicate—Dept. File

The University of Chicago—University Clinics
STORES ORDER
FORM 807

Auditor's Req. No.
Stores No. L03879
Please deliver the following item to Housekeeping Dept.
And charge to Housekeeping S & K Account
Check below the Stores Division to which order is to be credited
☐ Pharmaceutical Supplies ☐ Medical and Surgical Supplies ☐ Linen ☐ General Supplies
Date 8/16/37

Quantity Exchange	Quantity New	Description	Issued	Unit Price	Amount	Distribution
	1	Blue dress size 36			1.71	

Filled by
Audited by
Requested by
Approved by
Approved by

Forms that are part of the perpetual inventory maintained by the housekeeping department. Requisitions (lower right) are made out in triplicate, orders (above), in duplicate. Items received are entered on the stock card from the invoice. Front and back of stock card show how the inventory is carried forward.

service and others that purchase needed materials from the central stock room out of their individual appropriations. Requisition orders are made out in sets of four, one copy being kept by the person ordering the linen and the other three going to the department from which the linen was ordered. The new linen issued is stamped with the departmental marking and is sent to the laundry where the name of the particular division is embroidered in color, together with the month and year of issue. Each division of the clinics has its own identifying color.

Linen for the various floors is requisitioned daily. After it is delivered to the floors it is checked by the linen porter and the floor attendant and is placed in a linen room controlled by the floor supervisor, who is responsible for distribution as required.

Soiled linen is sent down through a chute into the soiled linen room where it is sorted, counted and listed before it is picked up by the laundry truck. Two commercial laundries under contract to the University Clinics handle approximately 3700 pounds and about $50 worth of special work daily.

To illustrate the huge amount of this laundry work, let us look for a moment at the poundage figures for March 1938 at the Albert Merritt Billings Hospital and the Bobs Roberts Memorial Hospital for Children. The figures for the month show 113,176 pounds of flat work and $1429.21 worth of special work, not including linens from the orthopedic department, which average about 300 pounds of flat work and about $2 worth of specials daily. To handle this amount of laundry requires an average of 22 trucks weighing 150 pounds empty and 360 pounds filled and 40 hamper bags holding 50 pounds each.

Used linen requiring sterilization is handled by the nursing department and, if soiled, it is sent to the laundry in special bags. Linen from skin disease cases also is placed in a specially labeled bag and goes to the laundry unopened. A distinctive label of red material is sewed on linens that are to be used for patients with skin diseases.

Both laundries give twenty-four hour service, with deliveries made at noon on each week day. Flatwork is weighed in the presence of the head linen porter and the laundry man. All items are then counted and checked with the carbon copy of the list made at the time the linen was sent out. Different forms are used for linen from the various departments and for special work and personal laundry.

Sheets and spreads are delivered in bundles of ten. Gowns, pajama coats and trousers are packed 25 to the

ONLY THESE SOLUTIONS ARE VACOLITER PROTECTED

B A X T E R ' S

DEXTROSE AND SALINE SOLUTIONS IN VACOLITERS

There's a supply of Baxter's solutions as close to you as your telephone

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CHICAGO NEW YORK

bundle and towels and pillow slips come in bundles of 50. This method facilitates counting, sorting and filling requisitions. Although torn linen is supposed to be segregated by the laundry this system is not entirely satisfactory. As a result linen room employes spend three hours daily checking linens for tears or strings torn from garments.

All torn articles are sent to the sewing room for repair. If an item is considered unrepairable it is charged off on the inventory list and torn up for use in cleaning. If possible, discarded pieces are made into other usable articles. Discards are specially stamped to obviate the possibility of their being confused with usable linen.

Besides repairing, the sewing room manufactures approximately 140 different items of linen. This amount includes 50 per cent of the hospital linen and also chair covers, curtains and draperies. During last March four seamstresses cut out 2389 pieces, completed the making of 2487 pieces and mended 3347 pieces. Besides this 451 pieces of employes' mending were done and sixty-seven hours was spent in discarding linen.

In a special book, known as the Bailey Linen Book, is kept a daily record of the linen going to and from the laundry. Any discrepancies noted are called to the attention of the laundry immediately, and at the end of each month this book is checked by the housekeeper and the laundry representative. The laundry is required to make an adjustment for any articles not accounted for. However, these discrepancies are extremely small.

For example, the following report for one month was made to the director of the clinics:

March 1938

	Pieces
Overage of one laundry	31
Shortage of same laundry	19
Overage of other laundry	66
Shortage of same laundry	45

Circulating linen is inventoried semiannually. The daily weight of flat work, pieces of flat work and specials are checked daily by the housekeeper's secretary. Any discrepancies in the weight or error in the number of pieces are settled immediately with the laundry. This bookkeeping takes two hours daily.

At the end of the month the laundry for each division of the clinics is added up and checked with the laundry's statement. After each statement is verified, it is marked O.K. by the housekeeper and taken to the business office for payment.

Each doctor prepares his personal washing for delivery to the laundry, making a list in duplicate of the various articles to be laundered and retaining a copy for checking purposes when the clean linen is returned. Differences are marked on a special slip and, if unaccounted for, the laundry is requested to make an adjustment.

An illustration of the setup of some of the divisions is as follows:

Private Division (Billings), twenty-four hour service: 1 large sheet, 1 draw sheet, 1 bed pad, 1 large pillow case, 1 small pillow case, 1 face towel, 1 bath towel, 1 wash cloth, 1 gown or pajamas and 1 bedpan cover. Spread and dresser scarf use varies, some patients, using one each day and other patients, one every two or three days.

Large Division (Billings), twenty-four hour service: 1 draw sheet, 1 large pillow case, 1 small pillow case, 1 face towel, 1 wash cloth, 1 gown or pajamas.

Three times a week: 1 large sheet, 1 bed pad, 1 spread and 1 bath towel.

When necessary, the large sheet is changed every day.

Older Child (Bobs Roberts), daily: 1 sheet, 1 large pillow case, 1 gown, 1 shirt, 1 pair of shorts or panties and 1 wash cloth; twice a week: 1 bath towel; three times a week: 1 face towel; once a week: 1 spread.

Infant (Bobs Roberts and Bailey), daily: 20 diapers, 1 pair hose, 1 shirt, 1 gown, 1 bib, 1 sheet, 1 small pillow case, 1 wash cloth; twice a week, 1 bath towel; three times a week, 1 face towel; once a week: 1 bedspread and 1 harness.

There are exceptions to these setups, depending upon the case, when more and various linen is used.

We have 3½ supplies of linen in circulation, in addition to a sufficient amount of isolation gowns, masks, caps, different kind of bags, covers, binders, pads, wrappers, towels and the like. One supply is on the patient's bed; one supply, on the division; one supply, in the laundry, and ½ supply, in the central linen room.

THE HOUSEKEEPER'S CORNER

• At Milwaukee Children's Hospital a method for removing oil stains from linens that are used in caring for patients with burns and similar cases has been developed after considerable experimentation. "We find that coarse salt, about five pounds of it, added to the average machine load of linen does the trick," says Elizabeth Reich, housekeeper. "The linen is then washed and rinsed in the usual way and the oil is completely removed."

• A thin coating of liquid wax will keep parchment paper lamp shades fresh and spotless, says Anna Walter, housekeeper at Columbia Hospital, Milwaukee. Before applying the wax, Mrs. Walter washes the shade with soap and water and wipes it perfectly dry. The wax gives a surface that is impervious to grime and dust. The shade may be cleaned by wiping it off with a damp cloth.

• When sheer silk curtains loose their crispness as a result of laundering, the finish may be restored by sizing. A good sizing is a solution of gelatin and water, in the proportions of one-half ounce of gelatin to 3 gallons of water. Dip the curtains in the mixture after they have been washed and rinsed carefully so that no soap remains. Stretch the curtains on dryers. The gelatin sizing gives the curtains a glistening sheen.

• A cement that is easily prepared and has the added advantage of strength and permanence may be made from litharge (lead oxide), glycerin and water. The usual method of preparing the cement consists of mixing 6 parts of glycerin with 1 to 3 parts of water and adding sufficient litharge to form a paste of the desired thickness. The water may be omitted if desired. Mix the cement just prior to use, since it sets rapidly, usually within an hour or so. If desired, about 10 per cent of iron oxide, Fuller's earth or silica may be added to the compound without affecting the final hardness or strength. When dry the cement has excellent ability to withstand the action of most corrosive solutions and dilute acids and is highly resistant to moisture and heat. The cement takes a good finish and paint adheres well.

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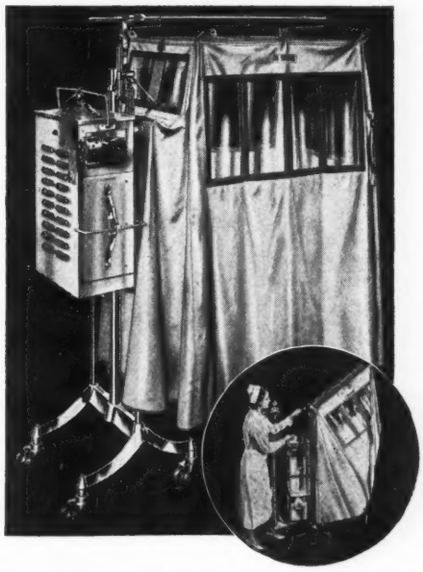

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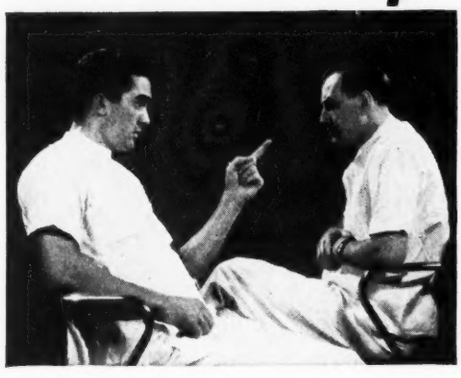

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Holiday Favors and Feasts

ANNA E. BOLLER

DESCRIPTIONS of the way in which Christmas is celebrated in various institutions all over the country make one feel that hospitalization during the holidays is a privilege, rather than a misfortune. It is apparent that the staff derives a great deal of pleasure out of the Christmas activities or it would not be so willing to put extra time and effort into the preparation for this celebration. In one institution, the cook delights in making the favors for the children herself. This activity draws together the workers of all departments and develops a spirit of cooperation which makes the holiday season a joy to everyone in the institution.

Last year many institutions prepared their Christmas trees by covering them with a dressing which, when hardened, looks like real snow. It is made by dissolving two cups of soap flakes in two cups of boiling water, then beating the mixture to a stiff foam. The lights should be put on the tree before the soap suds are applied.

The trees usually are put up several days before Christmas. In one children's hospital, Christmas wreaths with shining red satin bows are hung in each window. Each ward has its own tree, decorated by the children of board members, with the assistance of nurses and doctors to the accompaniment of excited directions from the little patients.

The occupational therapists find real joy in their work during this preholiday period. They assist the young patients in making Christmas cards, simple gifts, cardboard houses and other seasonal novelties. Older children are given sheets of Christmas carols early in the week and spontaneous group singing begins at this time. Each child, with the help of the nurses, writes a letter to Santa Claus, asking for the toys he wants.

Singing carols and each carrying a lighted candle, a chorus of nurses makes its way through the hospital corridors.

Usually he receives at least two of those requested.

In a middlewestern children's hospital, the Christmas day celebration is preceded by a party for the diabetic children. This is one occasion when these children on restricted diets may partake of refreshments without fear of overstepping, for all food served is carefully planned with this in view. It is a real test of the ingenuity of the dietitian to provide different menus each year. These children are clinic patients, ranging in age from 2 to 14 years. Tables suited to their various sizes are set with appropriate centerpieces, with a favor at each place.

It is generally conceded that the Christmas celebration should begin on Christmas Eve, as many people have their main celebration at home at that time. In one hospital, dinner is served by candlelight, supplemented by the lights on the Christmas tree. Around each tree marches a parade of orange elephants, raisin cats and animals. As bedtime approaches, everyone connected with the hospital is given an old-fashioned red tarlatan stocking stuffed with fruit, nuts and Christmas candy.

A dietitian in a southern hospital suggests a new setting for the traditional Christmas Eve candle. Small red birthday candles are inserted in the centers of cup cakes iced with white frosting, the candle being lit just before the tray is served.

In an eastern hospital, carols are sung on Christmas Eve by the student chorus of the nursing school. Each nurse carries a candle, as the procession makes its way through the corridors of the hospital.

Christmas morning is usually greeted by carols and a dietitian in one of the southern hospitals tells us that in her institution the carolers end up in the kitchen, where they are serenaded by the colored help, singing old Negro ballads. In another institution, where candles also are carried by the caroling nurses, they take their candles into the darkened

Santa makes his appearance at St. Christopher's Hospital, Philadelphia, bringing a bag of toys for the smallest patients. Below is a Christmas dinner tray, with those prime favorites, roast turkey, mashed potatoes, cranberries, asparagus, celery, milk, ice cream, animal cookies and hard candy.

nurses' dining room and eat breakfast by candlelight.

The breakfast trays usually contain Christmas cards made by the student nurses — sometimes a combination Christmas card and menu. A dietitian in a southern hospital describes a decoration for the breakfast tray, a single spray of white sweet peas, tied with Christmas ribbon. From a northern hospital, where fresh flowers are not available, comes the suggestion of a heavily-berried sprig of holly on the plate containing the glass of fruit juice.

In most children's hospitals, breakfast is either followed or preceded by the distribution of gifts. In a large eastern hospital, each child is dressed in a new bed jacket and each little girl adorned with a new hair-ribbon in readiness for Santa Claus' visit. Laden with huge baskets filled to overflowing with cretonne bags, he arrives with much jingling of bells. There is a bag filled with toys for each child. These bags are hung on the children's beds for the remainder of their stay, so that the contents may provide entertainment.

In another children's institution, where more generous gifts are impossible, small tarlatan stockings filled with nuts, candy and fruit and one inexpensive or home-made novelty are satisfactory.

In a middlewestern hospital an attractive gift-favor is made by a supervising nurse for the patients on her floor. She purchases inexpensive individual packages of bath salts. Into the top of each a lollypop is stuck and a face is painted on its cellophane wrapper with red nail polish. Red crêpe paper is gathered around the neck to resemble a cape with a frill at the top and tied with Christmas ribbon. A pipestem cleaner represents arms. The finished favor is greeted with enthusiasm by the patients.

The most elaborate favors are generally reserved for the Christmas dinner tray. Suggestions for somewhat different ones include:

1. Small paper baskets—in the center of which a candy cane is set with the curved end upward to represent a handle—are filled with hard candy or nuts. Red cellophane is draped over the basket and tied to the cane with green ribbon.

2. A popular favor in one of the children's hospitals is made by covering a soufflé cup with green paper and adorning it with a red yarn Santa Claus. A red ribbon cap with a tuft of cotton hair showing beneath is attached to the white paper face, which is trimmed with a white cotton beard.

3. Small square nut cups may be made from heavy red construction paper, folded in box shape and marked off with white ink to represent bricks. Santa Claus stickers or figures of Santa Claus cut from penny postcards are pasted on the inside, as if he were emerging from the chimney.

4. Another suggestion is to wrap candy in red cellophane, gather the edges together at the top and tie them with Christmas ribbon. A tiny Christmas tree or sprig of evergreen or holly is stuck in the top of the bag.

5. Baskets made of coconuts, tied with red tulle and filled with nuts, raisins and dates, supply an unusual touch.

6. Little individual Christmas trees may be made of cellophane sippers. Sixteen pieces of green sippers, cut 2 inches long, are gathered together, caught in the middle with wire and drawn tight. These branches are fastened to the end of a toothpick with red Scotch tape; the toothpick is covered with the tape and is stuck into a gum drop or marshmallow.

7. The apple Santa Claus, with marshmallow head, apple body, arms and legs of toothpicks strung with raisins and hands and feet of pecans is still being used with success, as is the marshmallow snow man, both of which were illustrated in this department several years ago.

New and unusual dishes are always interesting to the dietitian, but one

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contributor has summed up the general feeling as follows: "Experience has taught us that the Christmas dinners most enjoyed by all are the ones that include the dishes associated with the season. New dishes at this time are not appreciated. The food should be of excellent quality, well-prepared, and perfectly served. Never forget when planning the Christmas feast, that everyone, be he child or adult, likes a favor to take home with him."

Simple Breakfasts Are Served

Breakfasts for this feast day should be simple. The dietitian in one of the children's hospitals states that the caroling, gifts and a possible visit from Santa Claus are excitement enough for the small patients. Oatmeal with dates appears on many breakfast menus and an eastern hospital adds an interesting and unusual touch by using pink grapefruit baskets tied with green ribbon.

In a Milwaukee hospital, breakfast always includes the traditional stollen, without which no Christmas breakfast in that city would be complete. The recipe follows:

Stollen

1 pint milk (scalded and cooled)
2 yeast cakes
1 cup sugar
1 teaspoon salt
4 eggs, well beaten
1¼ pound butter
2 pounds flour
¾ pound seedless raisins
½ pound blanched chopped almonds
¼ pound candied chopped cherries
¼ pound candied chopped citron
¼ pound candied chopped orange peel
1 grated lemon rind
Pinch of nutmeg

Scald milk; add sugar and salt. When cool add yeast and 2 cups of the flour. Mix well, cover and place in a warm place to rise. Add the eggs and half of the butter, then add the remaining flour and coarsely chopped nuts and fruits. Set aside in a cool place or refrigerator until the next day. Turn out on to a floured board and roll to the size of the baking board. Soften (do not melt) the remaining butter. Spread part of it on the rolled-out dough, fold, repeat rolling and spreading the butter several times until all the butter is used. Cut into three loaves before the last folding and spreading, doing the three loaves separately for the last folding. Place in pans and allow to rise to nearly double their bulk. Bake in moderate oven for from fifty to sixty minutes. When done brush over the top with plain sugar and water frosting (flavored with vanilla or rum). When the cakes are cooled wrap them in wax paper and place them in cake boxes or crocks.

Dinner menus all list turkey as the main dish with varying accompaniments. Many dietitians feel that this meal is heavy enough so that no preliminary dishes are necessary, but when there is a first course, it is usually light. Some suggestions are: cranberry juice cocktail, spiced Concord grape juice, tomato juice served with canapés cut in the shape of Christmas trees and sprinkled with chopped parsley and pimiento and fresh fruit cocktail with orange slices.

Mashed potatoes almost invariably accompany the turkey and candied sweet potatoes are often served. The favored vegetables are buttered cauliflower, peas and carrots, broccoli with cheese or almond sauce and baked yellow squash. Cranberry sauce, of course, accompanies the turkey.

Salads, when used, carry out the popular Christmas color scheme. Rose apple salad and molded cranberry salad supply the red and green combination effectively.

In desserts, the dietitian may give her fancy wider rein, for in the hospital the traditional plum pudding is often considered a little too rich. A southern hospital serves hot mince pie in an unusual way. Cubes of sugar are dipped very quickly in a diluted solution of ethyl alcohol obtained from the drug room. One is then placed in the center of each piece of pie and the cubes are lighted just before serving. Care should be taken not to soak the cubes too long lest they crumble, or too far ahead of time lest evaporation take place preventing the burning.

Fancy Ice Creams

Many institutions, particularly children's hospitals, serve ice cream, either in the form of molds or appropriately decorated. One hospital serves it in green paper cups, the top sprinkled with grated sweet chocolate and a tiny sprig of a fir tree inserted in each cup. At another, vanilla ice cream is sprinkled with tiny red cinnamon drops and topped with an animal cracker. Raspberry ice, decorated with green snow, serves to carry out the color scheme and holiday motif in still another institution.

After the heavy dinner, a light supper is in order for Christmas night. The Christmas wreath salad, made of pineapple rings, spread with cream cheese and decorated with chopped green grapes, maraschino cherries, marshmallows and other fruit, is very popular. This is sometimes accompanied by cold turkey or other cold cuts with fruit and Christmas cookies for dessert.

Several good suggestions have been received for decorations in the nurses' and employes' dining rooms. Candlesticks are generally used on tables decked with sprays of long needled pine, holly, ivy and other greens. Utilizing tall red tapers, a beautiful centerpiece may be built of evergreen and holly. Pine cones dipped in silver and gold paint are combined with blue Christmas tree balls to form a glittering mound.

From another hospital comes the description of a novel candle holder made of a birch log, surrounded with cedar, balsam and pine branches and pine cones. This will keep from Christmas until New Year's Day.

Ivy leaves and branches of holly that have been sprayed with silver paint lend themselves to lovely arrangements.

Trees for Tables

Large Christmas trees for tables may be made by cutting, from 18 inch heavy green cardboard, two duplicate trees, each with 3 to 5 branches having the prongs slightly curved upward. Slit one 6 inches down from the top, the other 6 inches up from the bottom, sliding the two together and then opening them to make four sides. The trees are glued on substantial cardboard bases, which are then covered with greens and artificial snow. Sugared doughnuts are hung on each prong. For trays, smaller trees, approximately 5 inches tall, are made in the same manner and colored life savers are hung from the branches in place of the doughnuts. These trees make attractive favors.

In a middlewestern hospital, corsages and boutonnières made of holly leaves and berries and tied with Christmas ribbon are placed on the plate with the cranberry juice cocktail. These are much appreciated by the doctors and nurses.*

*Grateful acknowledgment is made to the following dietitians who contributed descriptions of the activities, favors and menus from their Christmas celebrations of last year:

Nell Clausen, Milwaukee Children's Hospital, Milwaukee; Carmen Getman, Millville Hospital, Millville, N. J.; Lillian F. Hack, St. Christopher's Hospital for Children, Philadelphia; Grace F. Headrick, Community Hospital, Beloit, Kan.; Eleanor Mathewson, Robert Packer Hospital, Sayre, Pa.; Alice Nesbit, Martha Jefferson Hospital and Sanitarium, Charlottesville, Va.; Genevieve Stephenson, Ingham Sanatorium, Lansing, Mich.; Beth Thomas, Norfolk General Hospital, Norfolk, Va.; Mary Grace Trout, Jefferson Hospital, Roanoke, Va.

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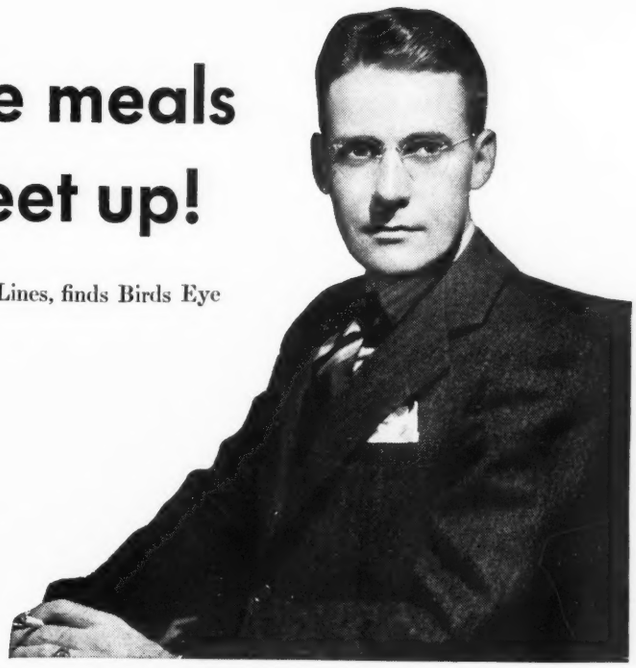

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Seafood Suggestions

ISABEL N. YOUNG

CANNED fish is one of the foods frequently neglected in the hospital dietary. This is unfortunate, because canned fish is an economical food, as well as one that will be enjoyed both by the hospital staff and by patients on a normal diet.

Canned fish and raw fish are complete proteins, contain vitamins A, B and D and are excellent sources of minerals. The canning process does not affect the food value of the fish. Tuna is usually packed in oil; mackerel is sometimes packed with spices and vinegar; otherwise nothing is added to the fish except salt for flavor.

In the accompanying table is shown the food value of the canned fish most widely available. Following are recipes for soups, chowders, entrées and salads.

Food Value Canned Fish (Edible Portion)

Fish	*Vitamins*	*Per Cent of Protein*	*Per Cent of Fat*	*Minerals*	*Calories per Pound*
Clams	A B D G	9	1	Calcium, phosphorus, copper, sulphur, iodine	250
Mackerel	A B	19	8.7	Calcium, phosphorus, copper, sulphur, iodine	731
Salmon (Pink)	A B D G	21.4	6.99	Calcium, phosphorus, copper, sulphur, iodine	696
Salmon (Red)	A B D G	20.8	11.22	Calcium, phosphorus, copper, sulphur, iodine	860
Shrimp					
Wet pack	A B D	20	0.5	Calcium, phosphorus, copper, sulphur, iodine	393
Dry pack	A B D	25.5	0.8	Calcium, phosphorus, copper, sulphur, iodine	508
Tuna, in oil	A B D	25.4	19.6	Calcium, phosphorus, copper, sulphur, iodine	1298

SOUPS AND CHOWDERS

Salmon Bisque

(Fifty Servings)

8 1 pound cans salmon
4 green peppers, ground
8 tablespoons onion, ground
8 teaspoons parsley, minced
4 quarts water
6 quarts milk
2 No. 3 cans tomatoes, strained
2 tablespoons sugar
2 tablespoons salt
1 teaspoon pepper
1 cup butter or substitute
1 cup flour
1 ½ teaspoons soda

Combine salmon, tomatoes, pepper, onion, water and parsley; simmer fifteen minutes. Run through coarse sieve. Add baking soda. Pour slowly into a hot white sauce.

Clam Chowder

(Fifty Servings)

7 No. 2 cans clams
1 pound salt pork, small cubes
2 cups onion, chopped fine
2 ½ quarts raw potatoes, ½ inch cubes
2 ½ quarts boiling water
2 ½ quarts tomato pulp
1 ½ teaspoons soda
2 ½ quarts scalded milk
½ cup butter
1 ½ teaspoons salt
¾ teaspoon pepper

Drain and cut clams, if large; lightly brown salt pork and onions; add potatoes, boiling water, tomato pulp, soda, milk, butter, salt and liquor from clams; cook 14 minutes or until potatoes are nearly done; add clams and simmer until clams are thoroughly heated, about 5 minutes. Serve with pilot crackers.

ENTREES

Mackerel and Mushrooms

(Thirty-Two Servings)

4 1 pound cans mackerel
4 No. 1 cans mushrooms
1 ¼ quarts bechamel sauce
2 cups grated cheese

Heat mackerel with liquid from can for ten minutes in moderate oven; drain mushrooms, place on mackerel; pour sauce over all; sprinkle with cheese; bake in moderate oven (350° F.) twenty-five minutes.

Sauce

(One and One-Quarter Quarts)

3 cups white stock
¼ cup chopped onion
¼ cup chopped celery
¼ cup chopped parsley
1 bay leaf
8 peppercorns
¼ cup butter
¼ cup flour
2 cups milk
½ teaspoon salt
¼ teaspoon cayenne
⅛ teaspoon nutmeg

Boil stock with onion, celery, parsley, bay leaf and peppercorns for thirty minutes; strain; melt butter, add flour, stir until smooth; add stock, milk and seasonings; stir constantly and boil until thickened, five minutes over a direct flame, or more in a double boiler.

Shrimp Pie

(Fifty Servings)

8 No. 1 cans shrimp
3 quarts white sauce
3 No. 2 cans peas
3 quarts mashed potatoes
½ cup butter

Drain, clean and cut shrimp in medium sized pieces; add shrimp and peas to white sauce; put in baking dish; cover with mashed potatoes; dot with butter and brown in hot oven.

SALADS

A basic recipe is given below that may be made with mackerel, salmon, shrimp or tuna. Variations may be made to suit individual tastes; chopped pickles, pimientos, green peppers or diced boiled potatoes may be added. Boiled dressing, mayonnaise, Thousand Island and Russian dressing are all good with fish salad. A boiled dressing is usually preferred when potatoes are used.

Mackerel, Salmon or Tuna Salad

(Fifty Servings)

10 1 pound cans fish
10 cups chopped celery
5 cups sweet pickle, chopped
18 hard cooked eggs, diced
Mayonnaise
Lettuce

Flake fish; combine with celery, pickles and diced hard cooked eggs; add mayonnaise to moisten; serve on lettuce; top with mayonnaise.

Christmas Supper Tray

Clear soup, assorted cold cuts, Christmas wreath salad, Christmas cookies and coffee. A small Christmas tree set in a soufflé cup covered with green cellophane forms a favor; fresh flowers also adorn the tray.—*Eleanor Mathewson, dietitian, Robert Packer Hospital, Sayre, Pa.*

Christmas Favors

Holiday Cruise Salad

On a base of julienne romaine place two slices of finger pineapple. Cover the pineapple with cottage cheese that has been mixed previously with chopped water cress. Place a triangle of pineapple in the center of the cheese to represent a sail. Cut a flag out of green pepper and place on the rear of the boat. Serve with French dressing.—*Arnold Shircliffe, Chicago.*

FOOD FOR THOUGHT

• Recent work on the relation of the temperature of storage of potatoes to the desirability of the cooked product should interest dietitians. In a recent article Mark A. Barmore, in *Food Research,* recommends, after having studied the effect of storage in various temperatures, that potatoes be stored at from 40 to 45° F. until about six weeks before they are used. By raising the temperature for the last six weeks to 60° F., the sugar content is reduced to a value low enough to prevent undue discoloration of the vegetable upon cooking.

• The answer to the dietitian's prayer has recently been developed by a Chicago poultry dealer—all white meat broilers. It is said that this condition is achieved by feeding a vitamin D preparation to chickens and by use of a light treatment of sunshine vitamin rays.

• The Homemakers' Bureau of Oakland, Calif., has recently published a splendid little booklet entitled "Cutting Remarks," which has to do with carving all kinds of meat, fish and fowl. It also describes the necessary implements; while planned for the household carver this instructive booklet should also prove valuable in the institutional kitchen.

• The winner of the Nobel prize for 1937 in physiology and medicine was Prof. Albert Szent-Gyoergyi, biochemist of Francis Joseph University at Szeged, Hungary, "for his discovery of the biological process of oxidation with special regard to vitamin C and the fumaric acid catalyses." Professor Szent-Gyoergyi was the first to obtain vitamin C or ascoric acid in crystalline form, and he has this year reported the discovery of a new vitamin—vitamin P—found in lemons and paprika. Vitamin P is closely related to vitamin C.

• The administrative section of the Illinois Dietetic Association has standardized a collection of recipes, which are being printed in the monthly bulletin of this organization. The therapeutic committee is making a collection of the newer diets which are receiving widespread use, including the low ionic diet (low sodium, high potassium with acid excess).

• Inasmuch as I am giving up the editorship of this department, I want to take this opportunity to thank all dietitians who have been so helpful in making the department a success, by contributing articles, ideas for this column, pictures, menus and recipes. I hope that you will give my successor, Miss DeHart, the same hearty cooperation that you have always given me. — ANNA E. BOLLER.

TOAST is an attractive and easily digestible form of carbohydrate, fine for
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SMOOTH DIETS
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January Menus for the Small Hospital

Jane E. Smith
Dietitian, Chicago Memorial Hospital, Chicago

	Breakfast		Luncheon or Supper				
Day	**Fruit**	**Main Dish**	**Soup or Appetizer**	**Main Dish**	**Potatoes or Substitute**	**Vegetable or Salad**	**Dessert**
1.	Grapefruit	Pork Sausage, Coffee Cake	Oyster Stew With Oysterettes	Assorted Cold Cuts	Hot Biscuits With Honey	Jellied Fruit Salad	Pound Cake, Butter Icing
2.	Stewed Peaches	Poached Eggs	Cream of Celery Soup	Sweet Potatoes With Bacon	Rosettes	Apple, Celery and Carrot Salad	Ambrosia
3.	Applesauce	Bacon	Cream of Tomato Soup	Creamed Sweetbreads on Toast		French Green Beans	Washington Pie
4.	Half Orange	French Toast With Syrup	Cream of Green Bean Soup	Jelly Omelet	Baked Potatoes	Mixed Vegetable Salad	Loganberries
5.	Prune Juice	Scrambled Eggs	Cream Purée of Vegetable Soup	Spaghetti With Meat Balls		Pear and American Cheese Salad	Apricot Whip
6.	Strawberry Rhubarb	Bacon	Corn Chowder	Vegetable Plate: Baked Stuffed Potato, Shoestring Carrots, French Green Beans		Sardine and Hard Boiled Egg Salad	Pecan Rolls
7.	Stewed Apricots	Soft Boiled Eggs	Vegetable Soup	Creamed Asparagus on Toast	Corn Muffins, Apple Butter	Cottage Cheese and Chive Salad	Queen Ann Cherries
8.	Half Grapefruit	Bacon, Coffee Cake	Tomato Bisque	Tunafish Salad	Hot Parker House Rolls	Buttered Peas	Dark Fruit Cake
9.	Fruit Compote	Scrambled Eggs	Chicken-Noodle Soup	Hot Roast Beef Sandwich, Gravy		Stuffed Tomato Salad	Baked Apple, Foamy Sauce
10.	Pineapple Juice	Rice With Cinnamon Grilled Ham	Cream of Spinach Soup	Eggs à la Goldenrod on Toast		Mixed Fruit Salad	Blueberry Cup Cakes
11.	Figs	Baked Eggs in Casserole	Broth	Canadian Bacon	Candied Sweets	Apple Salad	Gingerbread With Whipped Cream
12.	Whole Peeled Apricots	Pancakes With Syrup	Cream of Squash Soup	Baked Chicken and Noodles		Tomato Salad	Peaches
13.	Stewed Prunes	Bacon and Cinnamon Toast	Cream of Celery Soup	Poached Eggs on Toast	String Beans	Lettuce, Thousand Island Cressing	Gelatin With Chocolate Cookies
14.	Tangerines	Scrambled Eggs	Cream of Tomato Soup	Cabbage Roulettes	Corn Muffins		Sliced Pineapple
15.	Orange Juice	Coffee Cake, Pork Sausage	Cream of Beet Soup	Chicken à la King With Biscuits		Asparagus-Tomato Aspic Salad With Vegetable	Apple Brown Betty, Hard Sauce
16.	Fruit Compote	Soft Boiled Eggs	Cream of Pea Soup	Toasted American Cheese		Tomato Salad	Baked Apple With Cream
17.	Rhubarb	Bacon	Fruit Juice Cocktail	Ham Empanier	Date Muffins	Asparagus	Cherry Gelatin, Custard Sauce
18.	Sliced Bananas	Griddle Cakes With Syrup	Vegetable Soup	Macaroni and Cheese Croquettes	Crabapple Jelly	Cabbage, Carrot and Pineapple Salad	Apricots, Butter Cookies
19.	Half Orange	Scrambled Eggs	Fresh Shrimp Cocktail	Vegetable Plate: Candied Sweets, Cauliflower, Fresh Green Beans, Grilled Tomato		Pear and Cream Cheese Salad	Rice Krispie Macaroons
20.	Quartered Apples	Poached Eggs	Cream of Carrot Soup	Banana Fritters With Bacon		Lettuce Salad, Mayonnaise	Vanilla Pudding
21.	Stewed Apricots	Soft Boiled Eggs	Oxtail Soup	Baked Noodle Nest With Crabmeat		Buttered Peas	Fruit Cup
22.	Broiled Grapefruit	Bacon, Coffee Cake	Cream of Pea Soup	Creamed Sweetbreads and Mushrooms on Toast Points		French Beans, Peach Salad	Jelly Roll
23.	Fruit Compote	Poached Eggs	Broth	Rice Croquettes, Spanish Sauce		Stuffed Prune Salad	Blueberry Cobbler
24.	Tomato Juice	Scrambled Eggs	Cream of Asparagus Soup	Baked Sweet Potatoes, Quartered Apples and Bacon		Mixed Greens, French Dressing	Ice Cream
25.	Sliced Oranges	Bacon	Cream of Tomato Soup	Egg Salad Sandwich	Potato Chips	Banana-Nut Salad	Apple Tapioca
26.	Tangerines	Soft Boiled Eggs	Cream Purée of Vegetable Soup	Rolled Ham	Baked Potatoes	Brussels Sprouts	Strawberry Tarts
27.	Applesauce	Codfish Cakes	Cream of Mushroom Soup	Cheese Soufflé	Candied Sweet Potatoes	Fruit Salad	Cold Water Horns
28.	Prune Juice	Canadian Bacon	Cream of Spinach Soup	Scrambled Eggs With Ham	Hot Rolls	Tomato and Grapefruit Salad	Loganberries
29.	Orange Juice	Poached Eggs, Coffee Cake	Oyster Stew	Asparagus on Toast, Hollandaise Sauce		Cabbage Slaw With Pineapple and Marshmallow	Coconut Cake
30.	Rhubarb	Baked Eggs in Casserole	Cream of Carrot Soup	Baked Macaroni and Cheese		Apple, Celery and Date Salad	Oatmeal Drop Cookies
31.	Grapefruit	Bacon	Cream of Asparagus Soup	Baked Stuffed Potato With Eggs	Buttered Spinach	Cinnamon Apple Salad	Tapioca Pudding

Recipes will be supplied on request by Anna E. Boller, The Modern Hospital, Chicago. Space precludes listing of cereals, several varieties of which are always offered for breakfast.

Monthly News Review

Vol. 51 December 1938 No. 6

Commissioner Goldwater Urges Single Municipal Department of Medical Care

A single municipal department of medical care for New York City to take over the present department of hospitals and department of health as well as the medical services now being rendered by the welfare department was proposed last month by Dr. S. S. Goldwater, commissioner of hospitals, in a letter to Katherine Faville, director, Henry Street Nursing Service.

Following Doctor Goldwater's suggestion, arrangements were made by Doctor Goldwater and Dr. John L. Rice, commissioner of health, for a joint study of the problem by their departments. The New York Academy of Medicine also appointed a committee to investigate the situation.

In making his proposal Doctor Goldwater pointed out that great strides have been made in providing medical service for the indigent in New York City through the hospitals department. He stressed the fact that the health department also is engaged in a vast development of health centers with the same object in view. "Unfortunately its clinic program is not organically related to the rest of the city's therapeutic service," Doctor Goldwater added, noting that eventually all out-patient clinics will have to be brought into proper administrative relation with a hospital system.

Finally he called attention to the large medical service carried on by the welfare department which is unrelated to the other two services. "It does a patient no good to be shifted about from one city agency to another in the successive stages of his disease. There are loose ends and neglected needs of which your own district nurses probably know as much as anybody," he wrote.

"The existing lack of order, balance, coherence, continuity and consistency in the city's medical services has been the subject of a critical comment by the Academy of Medicine, the Hospital Survey of New York, the Hospital Council, the Welfare Council and other informed groups. In my opinion there is but one solution of the problem, namely, the creation, by charter amendment, of a new city department to absorb all of the medical services which the city is now rendering through its scattered agencies. A municipal department of medical care could not ignore the home medical needs of the indigent without incurring reproach."

Monument to Military Nurses Recently Unveiled

A memorial monument to the nurses of the U. S. Army and Navy was unveiled November 8 in the National Cemetery at Arlington. Six army and six navy nurses served as a guard of honor during the ceremonies. Major Julia C. Stimson, superintendent of the Army Nurse Corps, retired, made the presentation address.

Mrs. Paul Hube, who as Miss Ida Haentsche conceived the idea of the memorial when serving as a nurse in the Philippine Islands, came to Washington from her home in Switzerland to be present at the ceremonies.

The monument is a woman's figure in heroic size, done in Tennessee marble. The sculptor was Frances Rich, daughter of Irene Rich, motion picture actress. Mother and daughter attended the unveiling.

Penthouse for Physical Therapy

The physical therapy department of the Homeopathic Hospital, Wilmington, Del., is installed in a fine new penthouse, which was part of a rebuilding program that included remodeling of the service section of the hospital and a new wing for the nurses' home.

Hospital for Aged Poor Opened

A six story home for the aged and ailing poor in the Bronx, New York City, was formally opened November 6 when Mgr. Michael J. Lavelle dedicated St. Frances Schervier Hospital and Home for the Aged to the purpose for which it was erected. The building has been erected by the Sisters of the Poor of St. Francis and is the sixth Catholic hospital in the Bronx. It has 404 beds. There are glass enclosed solariums on the roof.

Rochester Insurance Plan to Admit Individual Subscribers

Rochester Hospital Service Corporation is now writing individual contracts for hospital care insurance. The first 133 individual applications received during the month of September came unsolicited and without much publicity, according to Sherman D. Meech, managing director.

The average age of the foregoing group is 44 years, while the average age of the plan's total membership is 37 years. More individual applications came from women than from men. It is hoped that the $9 and $18 rates, which are slightly higher than the group rates for Rochester, will be sufficient to cover hospitalization costs for individual subscribers. If not, adjustments will have to be made later.

Government Opens Second Hospital for Drug Addicts

A $4,000,000 U.S.P.H.S. hospital for drug addicts, the second such institution in the country, has been formally opened at Fort Worth, Tex. Comparable in function to the original hospital at Lexington, Ky., the new unit differs in design and arrangement. Less emphasis has been placed on the custodial features. About 300 beds have already been set up for patients. Another building for prolonged treatment for more advanced cases of addiction will be ready in 1939. Passed Assistant Surgeon William F. Ossenfort is the medical officer in charge.

Holy Family Dedicates New Building

The new building of the Holy Family Hospital in Brooklyn, N. Y., was formally dedicated at ceremonies at which the Most Rev. Thomas E. Molloy, bishop of the diocese of Brooklyn, officiated. Erected at a cost of $280,000, it has a bed occupancy of 75 and includes wards for men, women and children; also it has private and semi-private rooms with a complete surgical suite, emergency operating room, laboratories and administrative departments. The Right Rev. Monsignor Francis B. Connelly presided at the ceremonies at which friends of the hospital and the public were invited. Architects for the new building were Crow, Lewis and Wick.

TO THE PORT OF INDIANAPOLIS

● Many complications are involved in obtaining crude drugs from foreign countries. In this picture the botanist is shown taking a sample of ergot from the bottom of a shipping container. The drug is shipped from Portugal through New York to "Port of Indianapolis in Bond." The cases are first opened by customs officials who test the drug for adulterations and U.S.P. requirements. Most of the ergot received at the Lilly Laboratories is used in the production of 'Ergotrate' (Maleate of a New Ergot Base, Lilly) and 'Ergotrate H' (Hydracrylate of a New Ergot Base, Lilly).

'Ergotrate' and 'Ergotrate H' are used in obstetrical practice, and are in demand in every hospital. They represent the last word in ergot therapy. 'Ergotrate' is supplied in 1/320-gr. (0.2-mg.) tablets, and is available in bottles of 25, 100, and 500. 'Ergotrate H' is supplied in 1-cc. ampoules containing 0.2 mg. (1/320 gr.).

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PRINCIPAL OFFICES AND LABORATORIES, INDIANAPOLIS, INDIANA, U. S. A.

American Dental and Public Health Groups Consider National Health Program

General endorsement of the National Health Program and an insistence that dental services should play an important part in the development of such a program were voted by the American Dental Association at its meeting last month. The dentists recommended that the dental phase of the national health program must be approached primarily on the basis of prevention of dental diseases. This will require an extensive program of dental health education.

"The plan should include provision for rendering the highest quality of dental service to those of the population whose economic status, in the opinion of their local authorities, will not permit them to provide such service for themselves, to the extent of antepartum care, the detection and correction of dental defects in children and such other service as is necessary to health and the rehabilitation of both children and adults."

The dentists approved expansion of public health services, opposed compulsory health insurance but approved voluntary health insurance.

The American Public Health Association at its convention in Kansas City the last of October also approved the National Health Program and pledged itself to assist national, local and state medical and health groups in perfecting the plans.

It has been reported in the newspapers that plans were going ahead to introduce legislation in the next Congress to effectuate some parts of the program. Whether this will be confined to the sections that have not aroused controversy or will include also a section on compulsory health insurance has not been indicated.

Minnesota Institute for Administrators Is Extended

Numerous field trips and special studies will be included in the program as a result of the extension from three days to one week of the Minnesota Institute for Hospital Administrators. The institute, conducted by the Minnesota Hospital Association and the American College of Hospital Administrators in cooperation, will be held January 23 to 29, at the Center for Continuation Study at the University of Minnesota. Dr. William O'Brien, of the university faculty, will direct the institute, assisted by Ray Amberg of the University of Minnesota Hospital, and Gerhard Hartman, executive secretary of the American College of Hospital Administrators.

Attendance at the institute will draw administrators from Minnesota, 10 adjacent states and two Canadian provinces. One of the distinctive services planned by the institute is the formulation of a public relations program for hospitals and hospital administrators. Use will be made of the publicity mediums of the Twin Cities, including both newspapers and radio.

Community Chest Stickers

A sticker campaign for the purpose of asking contributors to the District of Columbia Community Chest to affix stickers to their pledges limiting them to those hospitals that are not discriminating against the Group Health Association has been started in Washington. The discrimination, it is said, includes the refusal of hospitals to accept patients, except in some cases, who are members of the Group Health Association.

Colorado Association Moves to Revise Its Constitution

The constitution of the Colorado Hospital Association will be revised to conform with that of the American Hospital Association as a result of action taken at the fourteenth annual meeting of the association in Denver, November 9 and 10. Appointed as a committee to prepare the articles of revision were: Frank J. Walter of St. Luke's Hospital, Denver; Dr. Maurice H. Rees, Colorado General Hospital, Denver, and Dr. H. A. Black, medical director of Parkview Hospital, Pueblo.

Officers elected by the association were: R. J. Brown, Porter Sanitarium and Hospital, Denver, president-elect; Mgr. John R. Mulroy, Catholic Charities, Denver, president; Dr. Theodore Williams, Denver General Hospital, first vice president; Sister Mary Sebastian, Mercy Hospital, Denver, second vice president; Grange Sherwin, St. Luke's Hospital, Denver, treasurer; Dr. B. B. Jaffa, Denver General Hospital, executive secretary and editor, and William S. McNary, director of the Colorado Hospital Service Association, trustee. Mr. McNary is the retiring president.

Stewardship Convention Views Public Relations; Adopts Hospital Policies

Lively interest in public relations programs was evidenced in the hospital section meetings of the National Stewardship Convention which met in Chicago on November 1 to 3. About 75 hospital officials attended the convention which attracted 500 or more religious, educational and other leaders.

The hospital section adopted a statement of policy that reads as follows: "Philanthropy and government both have responsibilities for the hospital care of the sick, particularly the sick poor. The increasing recognition by governments (federal, state and local) of their responsibility under this partnership, however, does not relieve philanthropy of its important responsibilities to the voluntary hospitals. Philanthropy must continue to support these hospitals so as to provide adequate physical plant, to enable voluntary hospitals to keep abreast of medical advances and to preserve the creative leadership of these institutions."

The voluntary hospital may well be considered a typical American institution, built by our citizens as a quasi-public institution to carry the burden of the general welfare of the seriously sick, declared Monsignor Maurice F. Griffin.

C. Rufus Rorem, director of the committee on hospital service, outlined the present financial situation of hospitals, pointing out that all present hospital endowment, if evenly spread over all hospitals, would provide an income of only about 6 cents per patient day. Even in voluntary hospitals, he said, only 6.3 per cent of total income is from endowments. "And 75 per cent of all hospital endowment is held by hospitals within 250 miles of New York City."

The 2700 voluntary hospitals of the United States are social capital and they need some free funds from endowments or gifts if they are to render the greatest good, Mr. Rorem declared.

It was the concensus of those who participated in the round table discussions that philanthropy need not die out in this country but that more effective and intelligent public relations methods must be followed if hospitals are to preserve their philanthropic support. It was agreed that public relations efforts must rest upon a basis of sound, intelligent and alert hospital administration. Without this, public relations efforts will become mere press-agentry, it was stated.

RECENT ADVANCES IN THE SCIENCE OF NUTRITION

IV. Some Accomplishments of Vitamin D Research

● By 1932, many of the basic facts concerning Vitamin D had been clearly established (1). At that time, the International system of denoting vitamin D unitage had not been universally adopted. However, the antirachitic potencies of a wide variety of biological materials had already been explored; the need for standardization of assay methods was appreciated; the minimum requirement of infants and children for vitamin D had been estimated; and the probable "multiple" nature of the vitamin definitely indicated.

Since 1932, the importance of vitamin D in human nutrition and the challenge of the many unanswered questions regarding this factor have served to stimulate research both in the clinic and in the laboratory. It is of interest to note some of the outstanding advances made in our knowledge of vitamin D which the past six years have brought.

It is now known that at least ten different sterol derivatives are capable of exhibiting the physiologic properties of vitamin D. Of these, only two may be considered of prime importance as far as practical application in human nutrition is concerned, namely, the activation products of ergosterol and 7-dehydro-cholesterol. The remaining forms are of considerable theoretical importance in that their identification has completely established the multiple nature of vitamin D (2).

Further research has also defined more closely not only the vitamin D requirements of normal infants and children, but also of premature infants and those peculiarly susceptible to rickets. Apart from conditions of pregnancy and lactation, the possible requirement of the human adult for vitamin D is still not known (3). The International system of expressing vitamin D potency has been universally adopted; bioassay methods have been standardized (4); and last but not least, a high degree of standardization has been attained, not only in regard to the antirachitic potency of Vitamin D preparations, but also as to the extent to which the vitamin D contents of certain foods should be increased by the various means available (3).

While some foods, including some canned foods of marine origin, are valuable food sources of vitamin D (5), no combination of common foods—as they occur naturally—can supply the demands of the infant and child for the antirachitic factor. Although there is no reason as yet to believe that the normal adult requirement for vitamin D is not largely fulfilled by a varied diet of protective foods, it is definitely known that the infant and child dietaries must be supplemented with or fortified by vitamin D.

It is in the formulation of basic diets for either infants or adults that commercially canned foods should prove especially valuable. Among the great variety of American canned foods are included special foods for use in child and infant feeding which, when properly supplemented or fortified, should meet the nutritive demands of those stages of life. For the normal human adult—whose diet hardly requires special supplementation—there are a large number of canned foods available which readily permit formulation of a varied diet of the so-called protective foods.

(1) 1932. J. Amer. Med. Assn. 99, 215 and 301.
(2) J. Amer. Med. Assn. 110, 2150.
(3) Ibid. 110, 703 and 1179.
(4) 1936. U. S. Pharmacopeia, XI Decennial Revision.
(5) 1935. J. Home Econ. 27, 658.
1933. Science 78, 368.

Inclusive Rate Plan Praised at Meeting of Illinois Catholics

The inclusive rate plan is considered to be an outstanding success by the Cleveland hospitals that have tried it, according to John R. Mannix, assistant director, University Hospitals of Cleveland, who addressed the meeting of the Illinois Conference of the Catholic Hospital Association meeting in Chicago on November 9 and 10.

Mr. Mannix reported that nearly all the hospitals in Cleveland have now adopted that plan. They believe that it enables patients to obtain better care, that it reduces complaints and that it simplifies bookkeeping on patients' accounts.

St. Francis Hospital, Evanston, Ill., also has had favorable experience with the plan according to reports presented at the meeting.

Graduate Institute for Nurses Held at College

A series of eight lecture courses, planned to give graduate nurses an opportunity to keep informed on new methods and discoveries in the medical field, was completed this month at Paterson State Teachers College, Paterson, N. J. The New Jersey State Nurses' Association sponsored the courses, mapped out by an advisory board which includes Edgar C. Hayhow, superintendent of Paterson General Hospital.

As another community service Paterson State Teachers College is this year offering for the first time a basic one year course designed to fit the needs of students who are planning to enter the nursing profession.

Picks Site for Hospital

A 146 acre tract, 2 miles from Fayetteville, N. C., has been selected as the site for the new $1,500,000 eastern North Carolina hospital for war veterans. On the tract is a system of breastworks constructed during the Civil War for the purpose of defending Fayetteville from the Union Army. The land is part of the old estate of Judge Robert Strange, who settled there at the beginning of the nineteenth century.

Expansion at Muhlenberg

The building program at Muhlenberg Hospital, Bloomfield, N. J., is progressing rapidly. This involves a complete new administration building with operating suites, also an addition to the ward building to provide increasing maternity facilities. The plans for the additions have been drawn by Crow, Lewis and Wick and the total cost is estimated at $275,000.

Mother Cabrini Is Beatified

The first American citizen to be beatified by the Church is Mother Francesca Saverio Cabrini, the founder of hospitals, orphanages and schools in 67 cities in various lands. The rites took place in Rome last month. Mother Cabrini died in Columbus Hospital, Chicago, twenty-one years ago after a life devoted to religious and charitable works.

Cardinal Mundelein of Chicago celebrated the mass of beatification for her in the presence of 2000 pilgrims including 22 Chicago nuns. Mother Cabrini, a native of Italy, founded the Missionary Sisters of the Sacred Heart.

New Hospital Council Formed by 17 N. Y. Health Agencies

The Hospital Council of Greater New York, with headquarters at 370 Lexington Avenue, New York City, has been formed within the month. It supersedes the Hospital Council of the City of New York, established in 1935.

The group represents both private and governmental interests and is the outgrowth of one of the recommendations of the recently completed Hospital Survey for New York. Seventeen organizations comprise the council, including the City of New York.

The purpose is to bring about a "closer interrelation of hospitals with other facilities for the care of the sick and with the public health and welfare agencies." It will make studies looking toward the improvement of hospital finances, according to the plan.

Labor and Professional Viewpoints Clash at Chicago Health Conference

Considerable difference in point of view regarding the future of medical and hospital service was indicated at the Chicago Health Conference, held on November 18 and 19. This conference, which was sponsored mainly by labor union leaders and social workers, heard from representatives of the medical, hospital, dental, social work and labor union groups.

Dr. I. S. Falk, chief of the division of studies of the Social Security Board and a member of the Technical Committee on Medical Care which drew up the National Health Program, quoted the section of the program which condemns voluntary health and hospital insurance systems as inadequate and indicated that the federal officials are planning to continue pushing for a compulsory health insurance organization in spite of the opposition to it expressed by professional groups. There was considerable support for his position from those who spoke for the labor unions but there was general opposition from the professional groups.

Drs. Rollo K. Packard and N. S. Davis III, speaking for the medical profession, acknowledged the existence of a problem but declared that compulsory health insurance is not the answer. Dr. Harold W. Oppice took the same position for the dentists, pointing out, however, that the American Dental Association had approved the idea of voluntary health insurance.

Alden B. Mills, managing editor of The Modern Hospital, quoted figures showing the rapid growth of hospital care insurance and suggested that it furnished a basis for extension to cover low income groups and others not now included. "It seems only fair to suggest," he said, "that, in those areas where voluntary plans are organized on a sound basis and are making reasonable progress, compulsory health insurance ought to be postponed for a period of five years to give these plans an opportunity to demonstrate how far they can meet the needs of the population. If at the end of five years it is apparent that the problem cannot be satisfactorily solved by voluntary plans, I feel sure that the hospital people of the United States will join with consumer groups in urging the development of a plan that will solve the problem."

Leon Des Pres, labor union attorney, stated that the Congress for Industrial Organization at its first annual meeting held last month voted to support the National Health Program but also decided to investigate the possibility of obtaining health protection on a voluntary basis pending the passage of compulsory health insurance laws by the various states. He stated also that, in general, the C.I.O. is in favor of obtaining funds to pay for health service by some kind of a tax other than a tax on the pay of the employe. On questioning, however, he indicated that this would not constitute a bar to C.I.O. members joining a system in which they had to meet part of the expense.

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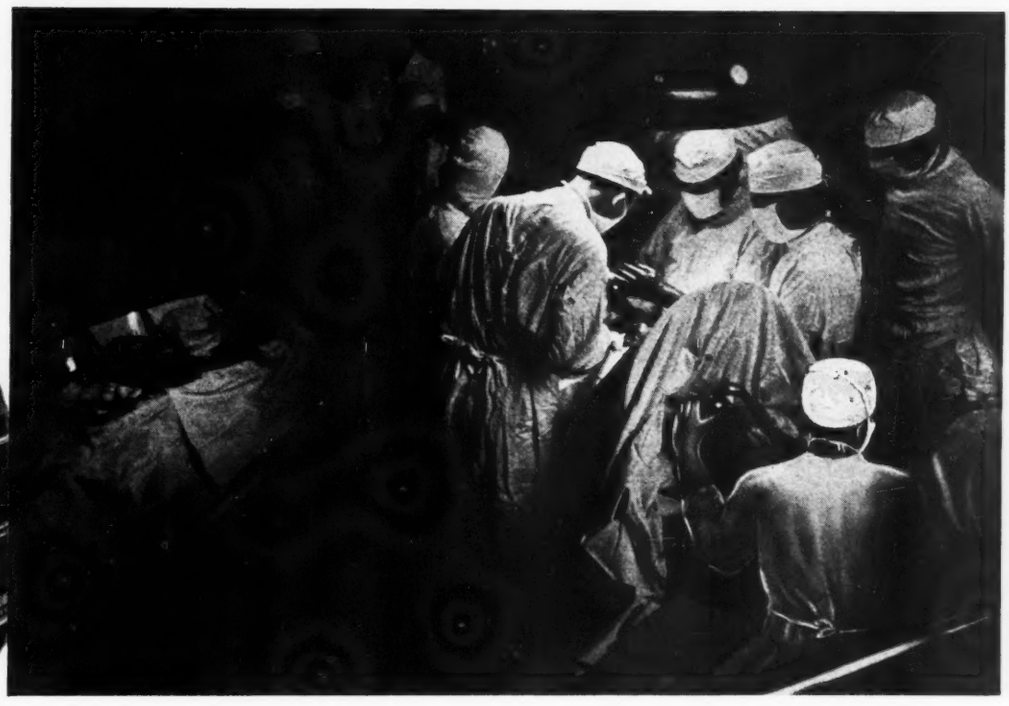

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Names in the News

Administrators

Transfers of the heads of three of Missouri's largest state hospitals, part of Gov. Lloyd C. Stark's economy and efficiency measures, have been announced by the governor. These include reassignment of DR. RALF HANKS from Fulton State Hospital to St. Joseph State Hospital; DR. ORR MULLINAX from St. Joseph State Hospital to Nevada State Hospital, and DR. T. R. FRAZER from Nevada State Hospital to Fulton. The shakeup also involved three assistant superintendents, nine resident physicians and 20 other members of the personnel of the three hospitals affected.

ETHEL GUILKEY is the new superintendent of Methodist Hospital, Sioux City, Iowa. She is the successor to DR. G. T. NOTSON, who recently resigned. Miss Guilkey formerly was superintendent of Deaconess Hospital, Billings, Mont.

BEULAH M. BROWN, superintendent, Soldiers' and Sailors' Memorial Hospital, Penn Yan, N. Y., has resigned. She has been superintendent of the hospital for the last four years. Resigning at the same time was MRS. MARGARET ROBSON, office nurse and bookkeeper for the last thirteen years.

BARBARA HUNTER, former superintendent of Little Falls Hospital, Little Falls, N. Y., will become superintendent of the hospital at Potsdam, N. Y., on January 1. Miss Hunter will succeed EVA T. NILES at Potsdam. ESTELLE LABRUYERE will become head of the hospital at Little Falls, N. Y. LEONARD LUBBOCK, superintendent of Faxton Hospital, has been retained by the board of trustees of Little Falls Hospital to reorganize that institution. Miss LaBruyere has been assistant superintendent of nurses at Faxton Hospital, Utica.

HULDA ERICSON is the new superintendent of New London Hospital, New London, N. H., succeeding GERALDINE CROWELL. Miss Ericson formerly was night supervisor at Franklin Hospital, Franklin, N. H.

MARTHA WEATHERLY will take over the superintendent's duties at Ticonderoga Hospital, Ticonderoga, N. Y., December 15. She formerly was superintendent of Jamestown General Hospital, Jamestown, N. Y.

SISTER MAY BLANCHE, a native of Toledo, Ohio, has been assigned as superintendent of St. Rita's Hospital, Lima, Ohio, succeeding SISTER MARY BERNARD, who has been ill.

GRAHAM F. STEPHENS is the new assistant superintendent at Evanston Hospital, Evanston, Ill. Mr. Stephens is the son of DR. GEORGE F. STEPHENS, superintendent of Winnipeg General Hospital, Winnipeg, Man., and a graduate of the hospital administration course at the University of Chicago.

DR. E. A. BABER, recently suspended as superintendent of Longview State Hospital, Cincinnati, is seeking to obtain a writ of mandamus to restore him to his position. The suspension was the result of "mismanagement and irregularities," it was charged by Margaret Allman, Ohio's welfare director, who has announced that removal charges will be filed at the end of the thirty day suspension period unless Doctor Baber resigns within that time. DR. N. W. KAISER, assistant superintendent of the hospital, has been named temporary superintendent.

DR. L. E. RAGSDALE, former head of the Tennessee Home and Training School for Feeble Minded Persons, Donelson, has been appointed superintendent of the Central State Hospital, Nashville. He succeeds DR. W. S. FARMER, who died recently.

COL. WILLIAM H. RICHARDSON, superintendent of Gorgas Hospital, Balboa, Canal Zone, for the last two years, will become the new superintendent of Corps Area Hospital on Governor's Island.

DR. ALBERT F. YOUNG, superintendent of the county hospital for mental diseases, Wauwatosa, Wis., for the last twenty-two years, will retire at the end of this year. His retirement will make it possible for the county board to carry out the long contemplated merger of the superintendencies of the hospital for mental diseases and the institution for chronic cases. The county board is expected to request the civil service commission to hold an examination to select one man to head both institutions.

DR. H. M. TURK, former acting superintendent of Lima State Hospital, Lima, Ohio, has been appointed permanent superintendent of the institution. Mr. Turk, who is the youngest hospital superintendent in Ohio, succeeds DR. GUY WILLIAMS, who has been transferred to Hawthornden State Hospital, near Cleveland.

DR. MORTON R. GIBBONS SR. will direct the hospital on the grounds of the San Francisco exposition next year. The hospital will be kept open permanently after the fair closes its doors.

LEILA E. WIGGINS, R.N., has resigned as superintendent of Memorial Hospital, Jackson, Tenn., to return to private practice.

ETHEL KIRCHOFER has resigned as superintendent of Berger Hospital, Circleville, Ohio, and has gone to her home at Wooster, Ohio, to be with her invalid mother.

Coming Meetings

1938

Dec. 28-30—Symposium on Mental Health of the **American Association for the Advancement of Science,** Richmond, Va.

1939

Jan. 23-28—**Minnesota Institute for Hospital Administrators,** University of Minnesota, Minneapolis.
Dec. 8-9—**Oklahoma Hospital Association,** Bittmars Hotel, Oklahoma City.
Feb. 20-23—**Association of Western Hospitals,** Seattle.
March 9-11—**New England Hospital Association,** Hotel Statler, Boston.
April 11-13—**Ohio Hospital Association,** Deshler Hotel, Columbus.
April 13-15—**Southeastern Hospital Conference** (Florida, Georgia, Alabama, Mississippi, Louisiana), Roosevelt Hotel, Jacksonville, Fla.
April 20-22—**Carolinas-Virginia Hospital Conference,** Roanoke Hotel, Roanoke, Va.
April 21—**Hospital Association of the State of Texas,** Fort Worth.
April 24-26—**Iowa Hospital Association,** Cedar Rapids.
April 26-28—**Hospital Association of Pennsylvania and Pennsylvania Association of Nurse Anesthetists,** Bellevue-Stratford Hotel, Philadelphia.
May 3-4—**Kansas State Hospital Association,** Topeka, Kan.
May 8—**Mississippi Hospital Association,** Gulfport.
May 17-19—**Hospital Association of New York State,** Hotel Pennsylvania, New York City.
July 25-Aug. 4—**Southern Institute for Hospital Administrators,** Duke University, Durham, N. C.
Sept. 21-22—**Canadian Hospital Council,** Toronto, Ont.
Sept. 19-23—**International Hospital Association,** Toronto, Ont.

Department Heads

DR. SOMA WEISS, associate professor of medicine at Harvard Medical School and director of the Thorndike Memorial laboratory at Boston City Hospital, has been appointed physician-in-chief of Peter Bent Brigham Hospital, Boston.

DR. FRANCIS H. SLEEPER, assistant superintendent of Worcester State Hospital, has been named director of the division of hospital inspection of the reorganized Massachusetts State Department of Mental Health.

HELEN SOMERS has been named acting supervising dietitian at Mount Sinai Hospital, New York, succeeding ADELINE WOOD, who recently resigned. Miss Somers has been a member of the dietary staff for thirteen years.

DR. ARTHUR E. BENJAMIN recently was elected president of the staff of Northwestern Hospital, Minneapolis.

HELEN PAYNTER has accepted a position as chief dietitian at Jewish Hospital, Philadelphia.

DR. EARL D. BOND has resigned as head of the department for mental and nervous diseases and as director of the institute for mental hygiene of the Pennsylvania Hospital, Philadelphia, to devote his time to medical research. In 1932 he won the Philadelphia award for his work at the institute where he conducted a school for problem children. Both positions will be filled by DR. LAUREN H. SMITH, an executive staff member of both units of the hospital since 1926.

BLANCHE THOMPSON has been named superintendent of nurses at the Dallas City-County Hospital, where she has been assistant superintendent for the last twelve years. Miss Thompson succeeds NELL ADAMS, who resigned.

DR. WILLARD C. RAPPELYE of Columbia University is the new president of the Association of American Medical Colleges. He succeeds DR. ALAN M. CHESNEY. Other officers named were DR. RUSSELL H. OPPENHEIMER, Emory University, president elect for 1939; DR. WALTER S. LEATHERS, Vanderbilt University, vice president, and DR. A. C. BACHMEYER of the University of Chicago, treasurer. DR. FRED C. ZAPFFE, Chicago, is the secretary. The group's 1939 meeting will be in Cincinnati.

DR. JAMES R. BORZILLERI, vice president of Columbus Hospital, Buffalo, N. Y., was elected president of the Western New York Hospital Council recently. He succeeds P. GODFREY SAVAGE, superintendent of the Niagara Falls Memorial Hospital.

DR. C. D. MITCHELL, superintendent of the Mississippi State Hospital, Whitfield, Miss., was elected president of the Southern Psychiatric Association at its recent meeting.

DR. LEWIS BARBATO has been named assistant superintendent of the Galveston State Psychopathic Hospital, Galveston, Tex., where he formerly was employed as a psychiatrist.

DR. EDGAR C. YERBURY, former assistant superintendent of Danvers State Hospital, has accepted an appointment as director of the division of mental hygiene in the Massachusetts state department of mental health. The post was held previously by DR. DOUGLAS A. THOM, international authority on hygiene.

Miscellaneous

DR. AUGUSTUS P. HAUSS has been appointed a member of the board of trustees for the new Southern Indiana Tuberculosis Hospital to be located near New Albany, Ind. Other members of the board are: DONALD DUSHANE, superintendent of schools, Columbus, Ind.; HARLEY WILLIAMS, Muncie, Ind., and JOHN P. F. THURSTON, Summitville, Ind. Mr. DuShane is a former president of the Indiana Tuberculosis Association.

JOSEPH W. BISHOP, son of HOWARD E. BISHOP, superintendent of Robert Packer Hospital, Sayre, Pa., has taken a position as accountant at St. Luke's Hospital, Philadelphia. Mr. Bishop is a graduate of the hospital administration course at the University of Chicago.

JULIA KIPP, a graduate of Evanston Hospital, Evanston, Ill., has taken a position as instructor in the school of nursing, Mound Park Hospital, St. Petersburg, Fla.

For the twenty-fifth consecutive time MRS. ROBERT R. HEYDENREICH has been elected president of King's Daughters Hospital at Staunton, Va.

ALFRED POST has succeeded MARY L. SCHERMERHORN as housekeeper at Blodgett Memorial Hospital, Grand Rapids, Mich.

ROBERT C. KNIFFEN of Blodgett Memorial Hospital, Grand Rapids, Mich., has taken a position as assistant to the superintendent of New York Hospital, New York City.

Deaths

SISTER MARY DE SALES REGAN, 67, superintendent of Holy Family Hospital, Manitowoc, Wis., for fifteen years, died on October 10.

Court Fight Looms Over Minneapolis Superintendent

The legality of the election of Dr. J. A. Herbolsheimer as superintendent of General Hospital, Minneapolis, may be settled by the courts if a court action now being drafted by four legal firms of Minneapolis is filed. These firms are seeking a restraining order against the public welfare board, of which Doctor Herbolsheimer was a member, and the civil service commission, arising out of complications brought about by his being a member of the welfare board at the time the election was held and of participating in the first voting.

Highlights of the controversy, as reported by Twin City papers, include: statements that Doctor Herbolsheimer will not be able to qualify before the civil service commission; a request that the examination be waived; a petition, signed by 300 employes of the hospital, asking the welfare board not to appoint Doctor Herbolsheimer, and a petition, signed by 38 interns and resident physicians of the hospital, asking the board not to consider the appointment.

Kings County Hospital Development Program Will Cost $5,653,000

Extensive building plans, involving the construction of four new buildings at Kings County Hospital, Brooklyn, at a cost of about $5,653,000, will extend the hospital facilities to meet the increasing demand for free medical care.

The projected units include a $2,735,500 building for chronic patients; a $1,430,000 building for mental patients requiring temporary diagnostic facilities; a building to relieve overcrowding in the clinics, to cost $1,087,500, and a central laboratory, to cost $400,000. Besides, there will be several smaller buildings constructed to provide additional service facilities and the entire Kings County Hospital area will be landscaped.

Vallandingham Resigns in Kentucky Political Fight

Resignation of Dr. J. L. Vallandingham as superintendent of Eastern State Hospital, Lexington, Ky., has been accepted by Governor A. B. Chandler, closing one phase of a political controversy that has involved heads of several state institutions and the state welfare commissioner.

Doctor Vallandingham, who had been removed from office last August by Frederick A. Wallis, welfare commissioner, had refused to vacate the superintendent's quarters. He later was reinstated by Governor Chandler and this move was immediately challenged by Mr. Wallis, who claimed that the recently enacted Chandler-Wallis Act gave him authority to remove from office heads of state hospitals. All state hospitals are administered under the Chandler-Wallis Act, which further provides that superintendents of state hospitals shall be appointed by the commissioner of welfare, upon the recommendation of the director of the division of hospitals.

As a sequel to the dispute Governor Chandler has removed Welfare Commissioner Wallis from office and appointed in his stead Margaret Woll.

Consider Treatment for Indigent

Hospital officials of Montgomery County, Pennsylvania, met with the Montgomery County commissioners recently to consider ways and means for putting into effect a contagious disease treatment program for persons who are unable to pay for such treatment.

LITERATURE *in* ABSTRACT

Conducted by E. M. Bluestone, M.D., and William B. Talbot, M.D.

Cost of Nurses' Illnesses

Illness among the nursing personnel is costly to the hospital. A study of the cost of nursing education and nursing service would be incomplete without a knowledge of the cost of illness of the two groups which compose the largest number of the nursing personnel: student and graduate staff nurses. An illness survey* was undertaken in which 300 schools in all types of hospitals were invited to participate. The daily average census in these hospitals ranged from 40 to 4000.

A total of 223 schools, representing 74 per cent, returned questionnaires. The average number of students in these schools for the year was 17,364, the average number of general staff nurses, 8794. An age range from 18 to 25 years for students, and from 21 to 35 for graduates may be assumed.

The study showed that the average number of days of illness per student was higher than per graduate for every month of the year. The annual average days of illness per graduate was 6.6; per student, 8.3. Diagrams show the comparison of both groups in the various geographic divisions.

The health of the student is under closer supervision, more emphasis is placed upon the health program for students than for graduates and students are required to go off duty more promptly and to stay off longer than graduates. The lower average illness among graduates may be caused by the lack of provision for sick leave with pay in some hospitals. If graduate staff nurses are not paid when they are off duty, they are inclined to remain on duty with minor ailments or to return before having recovered thoroughly.

Respiratory diseases, which occur most generally in the winter months, are the predominant cause of illness absence. The highest points of illness occur in January, February and March and the lowest occur during the summer months.

The illness incidence was heavier while students were on the pediatric and communicable disease services. For the year the average amount of illness per student on the communicable disease division was 9.4 days; the average time loss per student on the pediatric service was 10.6 days. The average annual illness for all clinical students in the home hospitals was 10.3 days, compared with 8.2 days for those on affiliation.

The health records as measured by days of illness of both graduate and student nurses were not as favorable as those of college students and women in the clerical, industrial and teaching fields.

The cost of caring for both student and graduate staff nurses in the 1285 hospitals connected with schools of nursing in the United States is somewhere between three and four million dollars annually, the illness cost of students being greater than that of graduates.

Owing to the illness of nurses, indirect costs occur for the patient and the nurse, the patient suffers from inadequate nursing care because the load of the nursing staff has increased beyond the time limits for consistently good nursing, the nurses on duty for longer periods accumulate fatigue and, sometimes, because of overwork their health is impaired.

*A Study of the Incidence and Costs of Illness Among Nurses, American Hospital Association, National League of Nursing Education, American Nurses' Association, June 1938. Abstracted by A. C. Donahue.

Salaries of Social Workers

This bulletin* presents the results of a study of salaries and related work conditions in the field of medical social work in 1937, serving as a base of comparison for similar investigations previously made. There were 507 different agencies employing 1908 workers that participated and the data are considered representative. The majority of the agencies are located in the larger cities of the New England, North Atlantic and North Central states. For the most part the medical social work staffs are small. Two out of five agencies among the 507 agencies reporting have one worker only.

Salary analyses are based on position, type of institution, inclusion of maintenance items, comparisons for six large cities and comparison between 1933 and 1937. Separate schedules are made for salaries of teachers of medical social work, for workers in crippled children's programs and for workers in miscellaneous agencies outside of hospitals.

Incidental tabulation of the educational background of medical social workers reveals that 51 per cent are college graduates and 64 per cent have had some credit for graduate school of social work training. A variety of interesting facts concerning the composition of medical social service staffs are summarized. The prevailing working week is one of thirty-eight hours, comprising five seven-hour days, and from three to four hours on Saturday. Vacation allowance and sick leave are not generous in a large proportion of the agencies. The majority of social service departments are no longer financed by special committees, reflecting a marked change in the practices of 15 years ago.

*Hurlin, Ralph G.: Salaries in Medical Social Work in 1937, Russell Sage Foundation Bulletin, 1938. Abstracted by J. Masur, M.D.

Changing Labor Policies

Labor policies of today are undergoing changes because of new labor laws, trade unions and public opinion.* A knowledge of current practice is of value to administrators in consideration of their own policies and in comparison of these policies with policies of similar institutions. This study is the report of the labor policies in practice March 1937 in 231 hospitals with a total of 6500 employees.

It is evident that few hospitals have established any standard method for computing the value or cost of maintenance. The value per week of a single room ranges from $7 to $1.75 and averages $2.88. Cost of breakfast averages 22 cents, dinner 31 cents, and supper 20 cents.

Because of the exceptional range of estimated cost of maintenance, the cash wages are tabulated but the groups are subdivided according to the type of maintenance given. Wages in the South are considerably lower than in other regions. The ratings show the highest wages generally are for white men; next, Negro men and white women, and lowest, Negro women. The large institutions have the highest average wage.

The present trend is for a working day and week below the respective eight and forty-eight hours. Workers in the South have the longest hours, while those in the West have the shortest. All but 29 of the hospitals give some vacation with pay. Sick leave with pay is given in approximately 50 per cent of the hospitals. Workmen's compensation is carried in only 75 per cent of these hospitals.

A survey of these data indicates a wide range of labor policies. The mode and mean are fairly good but there are individual institutions with poor standards.

*Augustine, Grace M.: Labor Policies in Hospitals. J. Am. Diet. A., May 1938. Abstracted by Amber Wolf.

COUNT YOUR CLEANING PENNIES

with Wyandotte Detergent

LET'S COUNT UP —

Say you have 500 square feet of painted surface that looks "gray in the face." Naturally, you want it clean — *really* clean. One pound of Wyandotte Detergent will do the job. Your old walls will greet you with a new face. Cost — six or seven cents, plus the time of your regular help.

***Now for the floors:* You can mop 100 square feet of flooring six nights a week for 52 weeks — 312 times a year — for less than a dollar a year, with Wyandotte Detergent — cost — only 2 cents a week.**

This same low-cost, high-quality cleaning is true of all Wyandotte products. Wyandotte Yellow Hoop for the laundry and Wyandotte dishwashing cleaners for the kitchen.

The whole Wyandotte family will help you count your cleaning pennies. If you do not have full information about *all* the Wyandotte products, your Wyandotte Service Representative will be glad to call on you at your convenience.

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BOOKS ON REVIEW

MONEY RAISING—HOW TO DO IT. *By Irene Hazard Gerlinger. Los Angeles: Suttonhouse,* 1938. *Pp.* xxi+311. $3.

HOW TO DO PUBLICITY. *By Raymond C. Mayer. New York: Harper & Brothers, Revised Edition,* 1937. *Pp.* xi+269. $2.50.

These two technical books contain considerable information for the beginner in the fields of publicity and public relations. Mrs. Gerlinger writes from a long experience as a voluntary crusader for good causes: churches, colleges, patriotic organizations and hospitals. She writes simply, directly and unpretentiously. It is stated in the blurb that she herself as a volunteer money raiser has raised over one million dollars for a variety of causes. To do this in the Pacific Northwest is a substantial achievement. An unusual feature of the book is a chapter devoted to fund raising counsel, containing descriptions of each of the leading firms and its work. Unfortunately these were prepared by the firms themselves and hence lack the critical value that would be desirable.

Mr. Mayer's book is another of the same kind. He gives technical details on how to obtain publicity for various types of projects, such as trade associations, commercial products, national organizations, conventions, social service and welfare organizations.

Neither book makes any serious attempt to develop a critical philosophy of public relations. Neither discusses such questions as "What is the basis for good publicity and promotion?" or "What relations should methods have to fundamental aims?" But, within their limitations, they are useful books.—ALDEN B. MILLS.

THE LIFE OF CHEVALIER JACKSON. *An Autobiography. New York: The Macmillan Company,* 1938. *Pp.* 229. $3.50.

At 73 the founder of the science of bronchoscopy finds his life work uncompleted. Simultaneously with the publication of his autobiography, Dr. Chevalier Jackson has announced that he will abandon bronchoscopy in the operating room for preventive bronchoscopy. This determined and humanitarian doctor, who fought for twenty years for the passage of the Federal Caustic Act because he had so often seen the disastrous effects of household lyes on the bronchial tubes of little children, will desert his practice to preach prevention to careless mothers.

The sensitive, modest, artistic and mechanically-minded doctor was born in Pittsburgh and brought up amid the rough surroundings of the western Pennsylvania coal mining district. From a Knickerbocker grandmother and a French grandfather he acquired the thrifty habits that enabled him to finance his education at Jefferson Medical College.

The book is illustrated with etchings and with sixteen full color reproductions of the author's own paintings.

Believing that 'bronchoscopy is too big a thing to be bottled up in one institution," Doctor Jackson set as his ideal the establishing of a bronchoscopic clinic in every large city. He traveled abroad and in this country demonstrating his technic, all the while fighting the tuberculosis that had thrice threatened his life. — RUTH TURLEY.

NEW PRODUCTS

Remote Control for Fire Stations

Two inherent weaknesses in the standpipe and hydrant types of fire fighting equipment are eliminated by the Rockwood pneumatic remote control system for fire hose stations, it is asserted by the Rockwood Sprinkler Company, Worcester, Mass. By making it possible to convert the standpipe and hydrant systems from normally wet to normally dry pipe service, the remote control unit has, it is said, eliminated the hazard of freezing and prevented the loss of large quantities of water annually where piping buried beneath the ground or embedded in concrete has sprung leaks.

The system is comprised of three parts; the remote control station, copper tubing and a dual guard deluge valve. One hose station is located alongside of each fire hose valve. All stations are connected by copper tubing installed in rigid conduit to the releasing mechanism of the dual guard valve, which is located in a heated room or small insulated valve house.

Uniform Chest Films

An x-ray "candid camera" that snaps a picture of a human chest in less than a hundredth of a second, thus obtaining a radiograph free from distortions which the movements of the heart sometimes cause in conventional x-ray machines, was recently demonstrated by the Westinghouse X-Ray Company. The outstanding features of the item are the elimination of mechanical time switches, plus the uniformity of the chest films produced regardless of the chest thickness or line voltage variations.

A small glass "trigger tube," no larger than a 65 watt lamp, controls the flow of 110 volt power from a light socket to a bank of condensers. Eight seconds later at the press of a button it releases this stored-up power as an 89,000 volt maximum discharge through an x-ray tube. The resultant invisible x-rays shoot out from the larger tube and through the chest of the subject who is standing 4 feet from the portable machine.

Paging New Literature

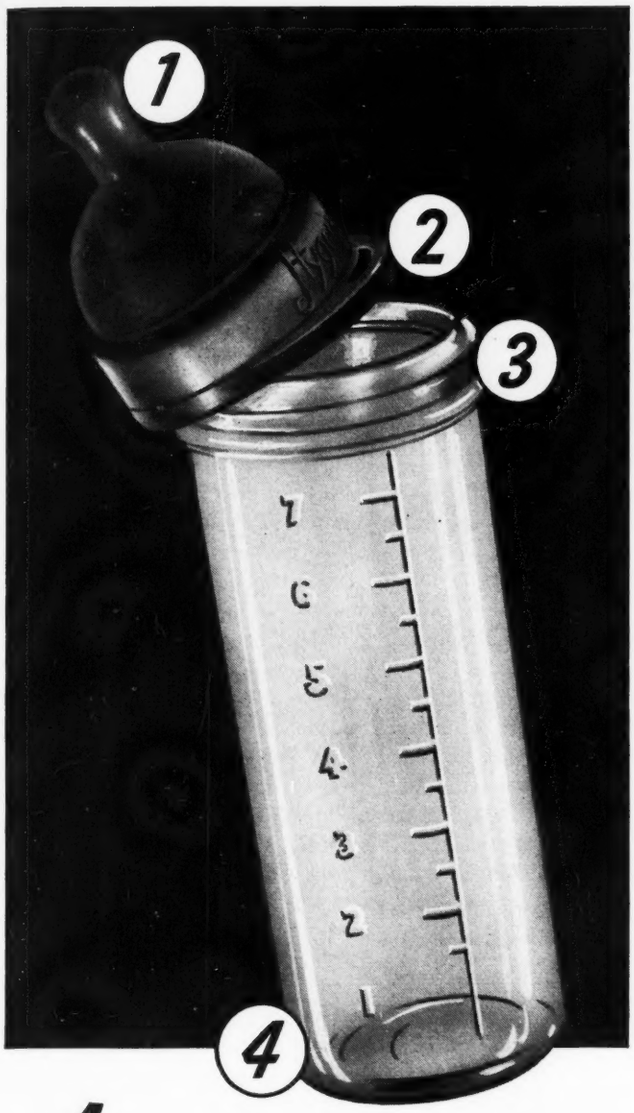
Savings in Production—A new principle in washing that gives greater production per laundry hour at a substantial saving is the theme of the catalog just released by the Henrici Laundry Machinery Company, Henrici Street, Boston, describing the Cyclone Hyper-cent washing machine.

Expressed in laundry men's language, the principle of the machine is: When you dump more suds, you dump more dirt. Fewer suds are necessary, thereby saving time in washing and in changing the bath.

The booklet explains by graphs, charts and text the method by which the washer is operated and shows the resulting increase in efficiency of operation claimed for it.

Priming Pump Purchasers—A practical education in the workings of vacuum pumps is offered to pump purchasers, particularly heating engineers, architects and contractors, in the attractive new bulletin on heating pumps and accessories published by C. A. Dunham Company, 450 East Ohio Street, Chicago.

So that readers of the booklet may easily consider heating



4 points OF SAFETY

INVENTED BY A DOCTOR who had been in active practice for over 20 years, Hygeia Nursing Bottle and Nipple have been proved completely sanitary.

1 Nipples can be had in three different shapes of teats to conform with the wide variety of babies' mouths. All shapes easily inverted for thorough cleaning.

2 Tab at the base of the nipple guards against fingers touching the sterilized surface.

3 Bottle is wide-mouthed so it can be properly cleaned and sterilized inside as well as out. No shoulder for dirt or germs to hide. No funnel is required.

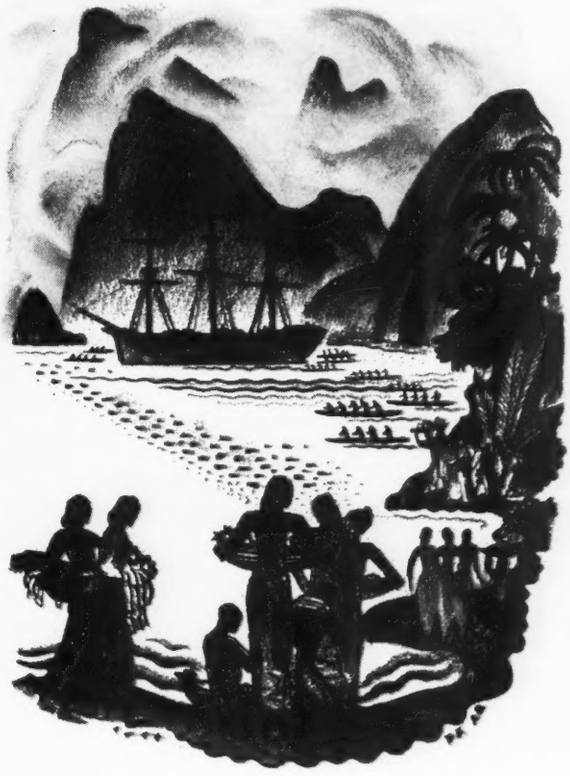
4 Smooth, rounded inner surface. No dirt-catching corners.

For these reasons and many others, Hygeia magazine advertisements tell mothers 41,000,000 times a month *"Safest because easiest to clean. Ask your doctor."*

HYGEIA COSTS LESS THAN ALMOST ANY OTHER BABY NECESSITY

HYGEIA NURSING BOTTLE CO. INC.
197 VAN RENSSELAER ST., BUFFALO, N. Y.

A scene in old Hawaii—the arrival of a sailing vessel—is pictured here by Millard Sheets



GOOD CHEER FROM HAWAII

You'll find a full cargo of zestful flavor and refreshment in every glass of fragrant, appetizing Dole Pineapple Juice from Hawaii . . . A beneficial and welcome beverage for patients . . . You, too, will enjoy its natural, field-fresh goodness. Dole Pineapple Juice is packed without added sugar, or preservatives of any kind.

Hawaiian Pineapple Co., Ltd., also packers of Dole Pineapple "Gems," Sliced, Crushed, Tidbits, and the new "Royal Spears." Honolulu, Hawaii, U. S. A.—Sales Offices: San Francisco, California.

pumps from the viewpoint of their individual requirements, it is arranged according to pump types and capacities, each type being illustrated and described in detail.

Because the vacuum pump is the heart of the heating system, the manufacturers feel that, by understanding system performance and characteristics as they relate to the basic principles of a vacuum pump, the prospective purchaser is in a position to make an intelligent selection of equipment and to ensure the satisfactory performance of the pump and of the entire heating system.

Correction—The Standard wall washing machine, manufactured by the Kay Engineering Corporation, 64 East Lake Street, Chicago, which was mentioned last month, is not electrically operated, as stated, but is of the hand pressure type. The elimination of the necessity for electric wires and outlets, it is learned, is one of the unit's important features.

Hospital Fashion Plate—All dressed up with plenty of places to go is Enduro, fashion plate of the hospital field. She will be equally at home in the kitchen, the utility room, the laboratory or the surgery, according to her sponsor, the Republic Steel Corporation, Cleveland. Much has been written about Enduro, sloganed "the modern metal for the modern hospital." The latest encomium is a booklet entitled "Enduring Sanitation With Hospital Equipment," which gives something of the family history of Enduro and describes its various uses and advantages.

Essentially, Enduro, which is the name of a large group of stainless and heat resisting steels, is an alloy of iron, chromium and nickel. It is said to be as sanitary as glass, its hard nonporous finish making possible the maintenance of an immaculate surface.

Things and People

By way of celebrating its golden anniversary, the Electric Storage Battery Company, Philadelphia, has issued a handsome booklet tracing the growth of Exide storage batteries since 1888 when the first "chlorine accumulator" was introduced to a skeptical world. The brochure illustrates a few of the hundreds of applications of the storage batteries, among them the emergency lighting system so important to hospitals.

The appointment of HARRY W. SMITH JR. as director of industrial gas publicity of the industrial gas section was announced recently by the American Gas Association, 420 Lexington Avenue, New York. Prior to this appointment, Mr. Smith was associated with the association in both its Cleveland and Los Angeles testing laboratories.

The first automobile x-ray unit, containing an elaborately equipped photographic darkroom and the most up-to-date portable x-ray equipment, has been delivered to the New York World's Fair. Its purpose is to provide the eight first-aid stations on the fair grounds with immediate x-ray service operated by skilled technicians. Another medical service on wheels to be used at the fair is an ambulance outfitted with modern equipment for giving immediate treatment in all sorts of asphyxial accidents.

Owens-Illinois Glass Company and the Corning Glass Works have announced the formation of the Owens-Corning Fiberglas Corporation, which will produce a variety of products made from fiber glass. The products to be manufactured by the new corporation are said to promise revolutionary developments in many fields of insulation, construction and industrial design.

READER OPINION

Radios in Hospitals

Sirs:

I am interested in the subject of radios in hospitals and a hospital worker here recommends that I write you about having the subject investigated.

I have recently spent some time in a hospital where the use of radios without ear phones was permitted. I objected strongly to this.

The regulation was that the door of the person's room using a radio be shut and the radio tuned down so as not to annoy anyone. But what actually happened was that the door did not stay shut as people went in and out and did not close the door again.

The nurses are very busy, indifferent and like radios. In the summer when windows are open, what good does a closed door do? What can be done to help those patients who want sleep and quiet and dislike radios at all times, sick or well? Even doctors to whom I have talked admit that they would hate to hear other peoples' radios when ill in a hospital.

I wrote to various well-known hospitals in Boston asking about their radio regulations. The usual answer was "the closed door" but from my own experience I know that solution is a failure.

Louise W. Jackson

8 Acacia Street,
Cambridge, Mass.

One of the Greatest Evils

Sirs:

We are manufacturers of certain items used by hospitals. After you have read this letter, you will understand, and we trust, appreciate why it is that we write you incognito, for while we have the full courage of our convictions, after all, we get our bread and butter from hospitals. While this letter criticizes the action of some hospitals, of course it doesn't criticize all of them.

The solicitation of contributions by hospitals from companies which are serving them with merchandise is one of the greatest evils existing in the hospital field today. We can understand thoroughly how patients, who have received excellent treatment, would gladly contribute to requests for funds. We think solicitations from people like that are fully warranted. Those living in the territory served by an important hospital, who have been or could be patients of that hospital at any time, could be asked with dignity for assistance in maintaining the proper activities of hospitals, which have been so affected by present and past economic conditions.

But, any hospital superintendent who approaches a manufacturer who furnishes the hospital with merchandise with the implication "You had better come through here, or else there's a chance you won't get a continuation of our patronage" is doing his own hospital and all hospitals a great injustice. Any company that's in business has got to make a profit to stay in business. If we who furnish hospitals are obliged day after day to make contributions of this sort, there is just one place that they are ultimately going to come from, an increased price to the hospital consumer.

This situation has existed so long partly because of the fear on the part of the manufacturer that his business would be greatly injured if it were known that he publicly expressed disapproval of such procedure. We are

frank to admit that we cannot initiate an active measure of any sort against such procedure, but certainly you, as the editor of the leading hospital publication of the country, must recognize that what we are telling you is the truth.

One Who Would Like to See
All Hospital Contacts Above
Reproach

Our editorial columns have frequently condemned this shortsighted and unethical procedure (e.g. see "Contributions by Duress," January 1938). However, the time has now come when the Hospital Exhibitors' Association and national, regional and state hospital associations should take a firm stand against such pernicious practices. They seem to be spreading and, if they do, ethical hospitals will find themselves at an even greater disadvantage. A pussyfooting policy will no longer be effective.—ED.

Injustice to Fabius

Sir:

With reference to your editorial "Fabian Practices" in the August number of The MODERN HOSPITAL, I would suggest that you check up on ancient history. You certainly do a great injustice to Fabius, who was noted not for his procrastination, but for his caution, a quality which I trust will always have a place in every hospital.

James U. Norris,
Superintendent
Woman's Hospital,
New York

Utilizing Hospital Beds

Sirs:

Returning from my vacation just a week ago, and having sandwiched in a field trip, I just have had opportunity to read your article "How Many Beds Are Enough?" and want to congratulate you for it. I am sorry that we could not furnish the daily experience in Farmville in time that it might have been fully compared with the other hospitals you studied.

Size is a considerable factor in the possible per cent of utilization. The smaller the hospital the lower the maximum practical utilization. This may be illustrated in this way, small hospitals of necessity must have small wards while larger hospitals may have units containing three, four or five times as many beds. If one bed is not occupied in a 4-bed ward, the utilization for that ward is 75 per cent, whereas one unused bed in a 20-bed ward gives a utilization of 95 per cent. Doctor Rankin and I believe that around 60 per cent is about as much as a 50-bed hospital can reasonably expect, especially if colored patients must be segregated.

H. J. Southmayd
The Commonwealth Fund,
41 East 57th Street,
New York

261 Ways to Save

Sirs:

I have just read with much interest Dr. Morris Hinenburg's article "261 Ways to Save."

It would be most useful to be able to distribute to all persons concerned reprints of the above article. I would be glad to pay a reasonable price for about 75 such reprints. I suspect there will be considerable demand for reprints of this very informative article.

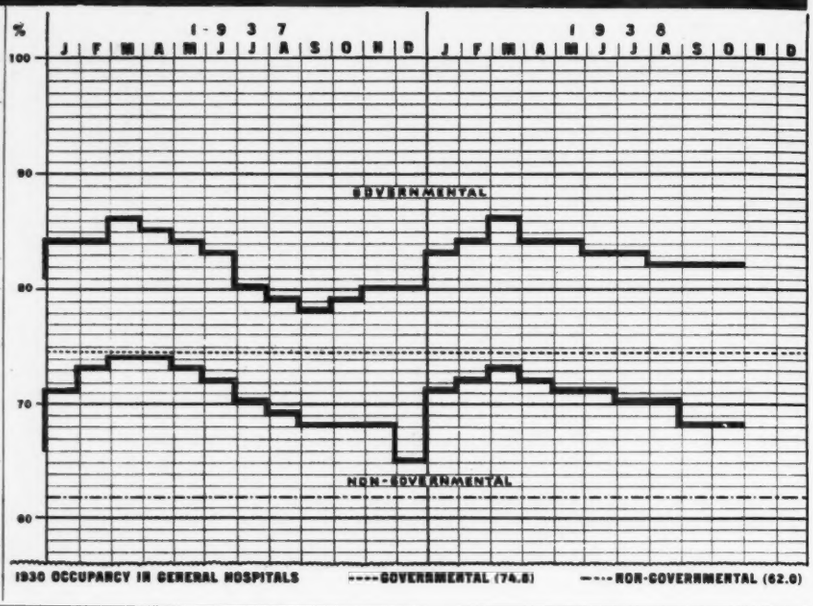
Olin L. Evans
Homeopathic Medical and
Surgical Hospital,
Reading, Pa.

The MODERN HOSPITAL *is always glad to provide reprints to its subscribers at cost. Any orders for reprints of this article that are received by December 31 will be pooled and the cost allocated among those who order. The more orders received the lower will be the cost. In any event it will not exceed 10c per copy.*—ED.

HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data on Reporting Hospitals[1] Hosp.	Beds[2]	1938 Oct.	1938 Sept.	1937 Oct.	1937 Sept.
Government						
New York City	17	11,328	98*	96*	85	84
New Jersey	4	2,122	85*	85*	87	84
Washington, D. C.	1	1,220	70*	70*	65	65
N. and S. Carolina	13	1,579	74	73	65	66
New Orleans	2	2,466	98*	95	97	97
San Francisco	3	2,255	86	85	85	86
St. Paul	1	850	66	66	67	65
Chicago	2	3,619	85	84	83	81
Total[4]	43	25,439	82*	82*	79	78
Nongovernment						
New York City[3]	68	15,194	66*	66*	71	66
New Jersey	59	9,772	65*	65*	66	64
Washington, D. C.	9	1,818	71*	71*	75	73
N. and S. Carolina	110	7,297	65	67	65	66
New Orleans	7	1,153	74*	78*	67	68
San Francisco	16	3,178	69	68	76	75
St. Paul	8	964	70	70	62	65
Chicago	17	3,288	63	59	65	61
Cleveland	5	1,586	71	71	76	74
Total[4]	299	44,250	68*	68*	69	68

[1]Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. [2]Including bassinets, usually. [3]General hospitals only. [4]Occupancy totals are unweighted averages. *Preliminary report. Complete occupancy figures for January, 1933, to October, 1937, are given on page 834 of The Sixteenth Hospital Yearbook.



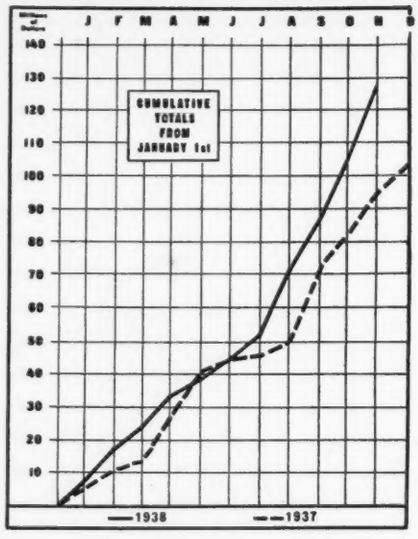
Construction Forges Ahead but No Rise in Occupancy

The usual seasonal rise in occupancy has not appeared in the nongovernment hospitals, according to the figures for October 1938. Government hospitals, however, showed an advance in occupancy in individual hospitals although the average for the group reporting was only half a point higher, not enough to show in our tables.

In comparison with figures for the same period during 1937, occupancy in government hospitals has risen three points, while in nongovernment hospitals it has declined one point. The seven hospitals reporting in New Orleans showed the sharpest decrease, 4.1 points between September and October. This was the more noticeable since occupancy in voluntary hospitals in New Orleans has risen almost without a break from October 1937, when the average was 67.3, to August 1938, when the occupancy level was at a peak of 79.4.

Hospital construction continues to increase significantly. The total expenditure from January 1 to November 21 is $127,042,676, which is a gain of approximately $30,000,000 over the figure for the same period of last year. Most of the new money going into hospital construction is for the expansion of existing facilities. The totals for the current year, for example, are as follows: $90,968,210 for additions to existing plants; $30,881,800 for new hospitals; $3,323,700 for new nurses' homes, and $1,819,920 for alterations and modernizing.

HOSPITAL CONSTRUCTION



Between October 24 and November 21, 122 new construction projects were reported, with 119 giving costs of $23,008,485. Of these, 21 were new hospitals at a total cost of $7,753,000. Eighty-eight additions, 85 of which reported costs, totaled $14,474,802. Eight new nurses' homes, costing $45,793, and five alteration jobs, costing $384,890, accounted for the rest of the money spent during this period.

General market prices as reported by the *New York Journal of Commerce* have fluctuated little, on the average, during the four weeks from October 31 to November 21, declining only 0.4 point. Fuel and textile prices have remained virtually unchanged and building materials have increased 0.3 point. Food prices dropped from 69.1 on October 21 to 67.6 on November 7, thereafter climbing to 68.3 as of November 21.

Drugs and fine chemicals remained stationary after dropping 0.1 point, from 182.6 on November 21 to 182.5 on November 7, according to the figures of the *Oil, Paint and Drug Reporter.*

The National Industrial Conference Board reported distinct gains in employment and pay rolls in 25 industries. In September the average work week was 36.3 hours as compared with 35.2 hours in August. Over the same period, average hourly earnings advanced from 71.1 to 71.3 cents. Average weekly earnings in September were $25.82 as against $24.93 in August, a gain of 3.6 per cent.

THE FAMOUS SIMMONS *Beautyrest* FOR HOSPITAL USE

It provides greater comfort for patients . . . . induces more complete rest and relaxation.

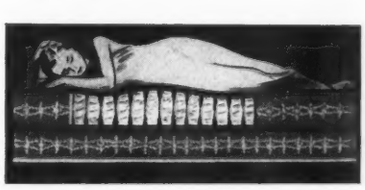
The Simmons Beautyrest is highly appreciated by hospital patients. Its soft, resilient surface adjusts itself to every position of the body. There are no lumps, no hard spots, no sagging. It is the most comfortable mattress science has so far developed.

The Beautyrest is different from other inner-spring mattresses. Instead of one continuous spring unit, it has 837 separate coils, each in a cloth pocket. These coils work individually and "give" only at the point where weight is applied.

Many leading hospitals have used the Beautyrest for years. They find that, in addition to its extra comfort, the Beautyrest is durable enough to make it completely satisfactory for hospital use.

For additional information about the Beautyrest or other Simmons mattresses, write

This cut-away section shows the interior of the Beautyrest. Each of the tiny coil springs is enclosed in a cloth pocket. Each of them can work separately of the others. A patented method of attaching coils to borders makes a sag-proof edge that will not break down.



With a continuous spring unit, a weight applied at one point causes surrounding areas to sag. In the Beautyrest, the individual coil construction "gives" only at the point where weight is applied. This causes the Beautyrest to fit the curves of the body in any sleeping position.

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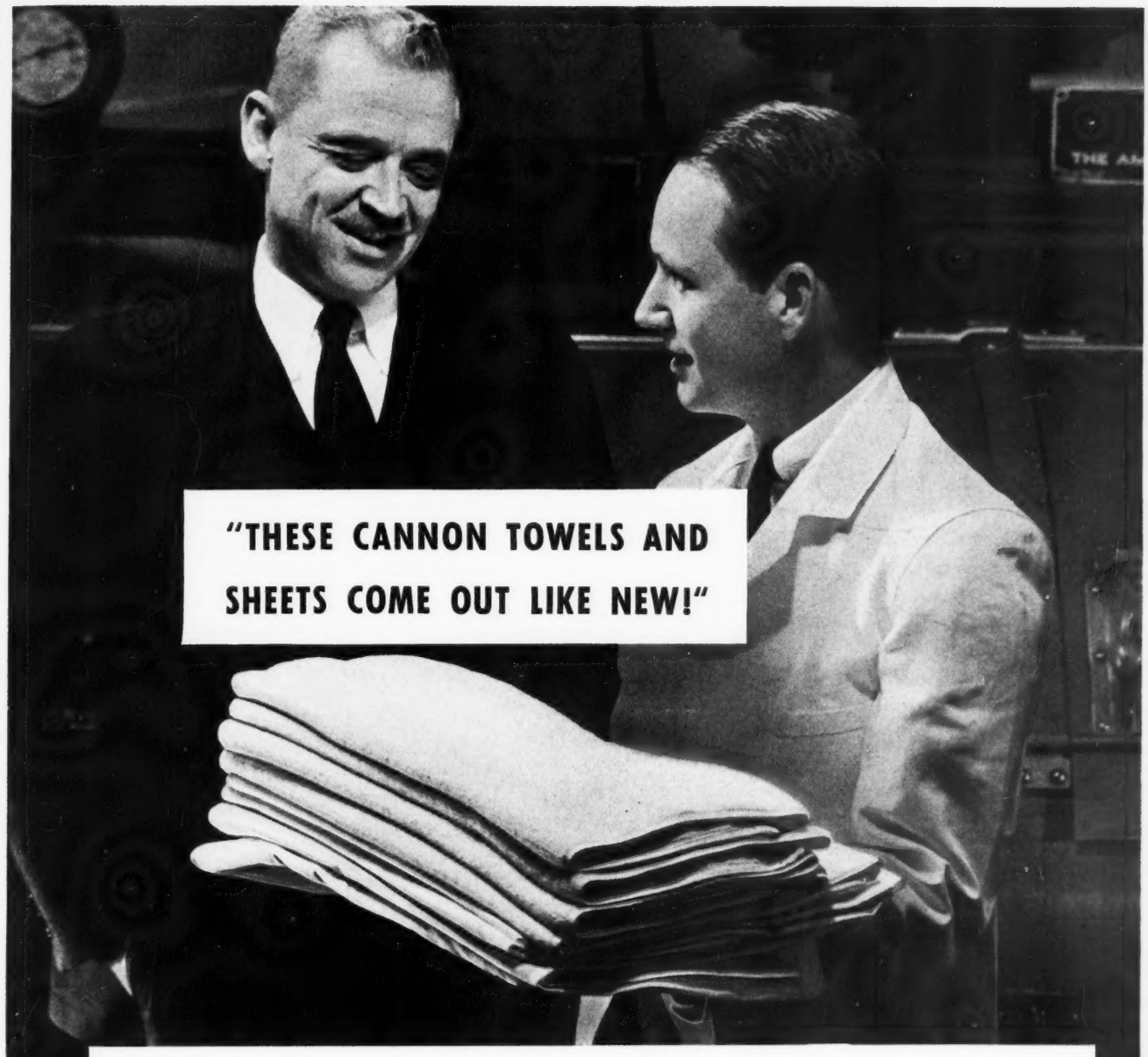
Continued on page 12



It's true that Cannon towels and sheets will hold their texture and strength for many more launderings, many more months of constant use. Their weaves, their materials and their standards are the result of Cannon's long experience with hospital requirements.

And it's equally true that Cannon products are the "best buy" on the market, for Cannon's experience plus its larger volume make possible a famous policy: *Better quality at regular prices, regular quality for less!*

This money-saving policy covers the complete Cannon towel line: Bath towels with regular or reinforced hemmed selvages; fine-quality cotton or union huck towels; wash cloths; bath mats; dish and glass towels — all name-woven or plain. It makes Cannon sheets the "best buy" too: Cannon Muslin, Cannon Utility Percale, Cannon Fine Percale.

Hundreds of hospitals have subtracted from their linen costs and added to their efficiency by choosing Cannon products. Get the facts — today. Cannon Mills, Inc., 70 Worth St., N. Y. C. World's largest producers of household textiles—the best-known and most-used brand in your patients' homes.

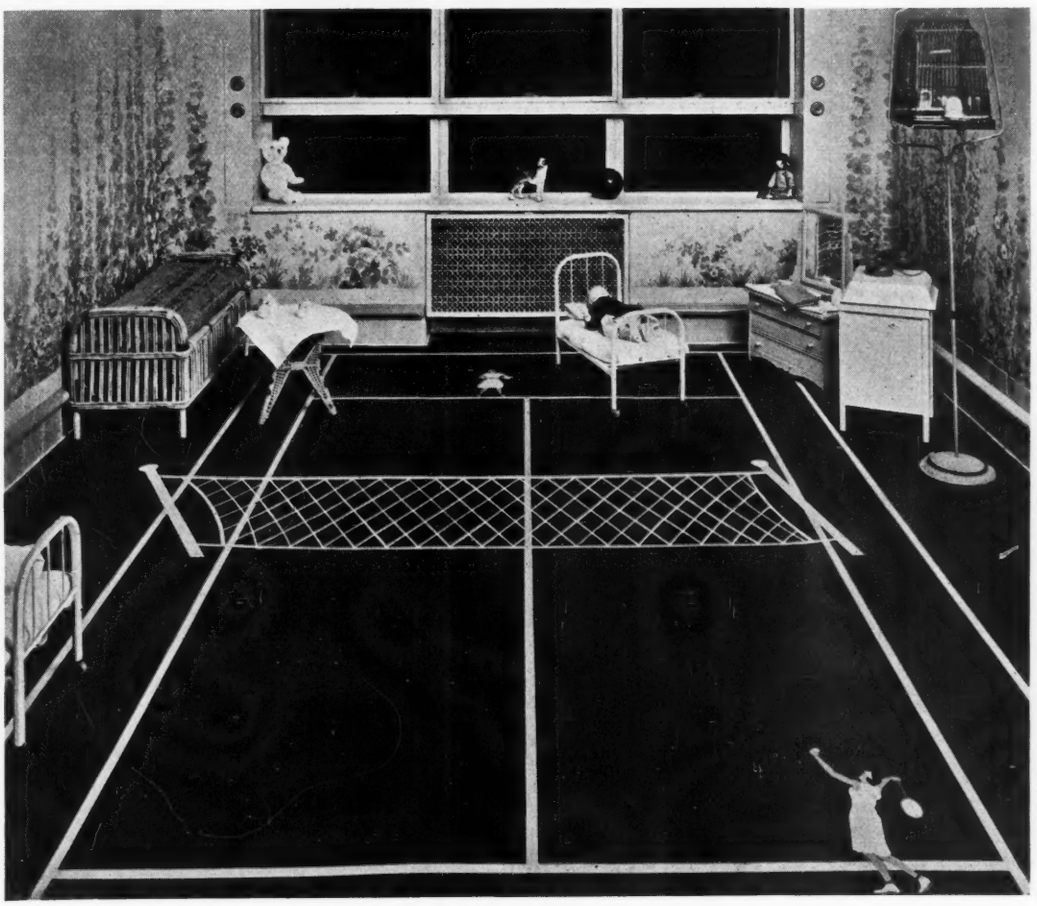
Cannon Towels and Sheets

INDEX OF ADVERTISERS

Continued from page 10

This a HOSPITAL room!

Shriners' Hospital for Crippled Children uses novel floors to make rooms homelike



SAN FRANCISCO SHRINERS' HOSPITAL FOR CRIPPLED CHILDREN *adds a cheerful touch to its girls' playroom with a gay floor design executed in Armstrong's Linotile (Oil-Bonded). Our Bureau of Interior Decoration will be glad to suggest appropriate designs for special rooms in your hospital. Write for booklet and full details.*

Durable, sanitary Linotile (Oil-Bonded) is easy to install in special designs

NOTHING so quickly rids a hospital room of that "institutional look" as colorful floors with cleverly designed insets. In the play room shown above, the tennis net and players are cut from various colors of Linotile (Oil-Bonded) and inset in a field of green Linotile. In rooms for adults, more restrained but equally attractive designs can be installed.

Linotile—made by the makers of Armstrong's Linoleum — is even more resistant to denting than battleship linoleum. Maintenance is easy and inexpensive because the rich colors run through the full thickness of the material. Daily sweeping and periodic washing and waxing keep them fresh and attractive.

Linotile is resilient and comfortable. Find out more about its many advantages for your hospital. Write today for the free, color-illustrated book *Handlaid Floors.* Armstrong Cork Company, 1210 State St., Lancaster, Pennsylvania.

For hospitals, Armstrong manufactures the only complete line of resilient floorings: Linotile (Oil-Bonded), Linoleum, Asphalt Tile, Cork Tile, and Armstrong-Stedman Reinforced Rubber Tile. Therefore our Architectural Service Bureau can offer you or your architect unbiased suggestions as to the best type of resilient flooring for any area in your hospital.

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This Western Electric instrument amplifies heart sounds up to 100 times the intensity obtained with an ordinary acoustical stethoscope. Its filter circuit enables you to suppress normal heart sounds, thus isolating and accentuating the sounds being investigated.

The Electrical Stethoscope is light and easily carried on house calls. For full details, write to Graybar Electric Co., Graybar Bldg., New York.

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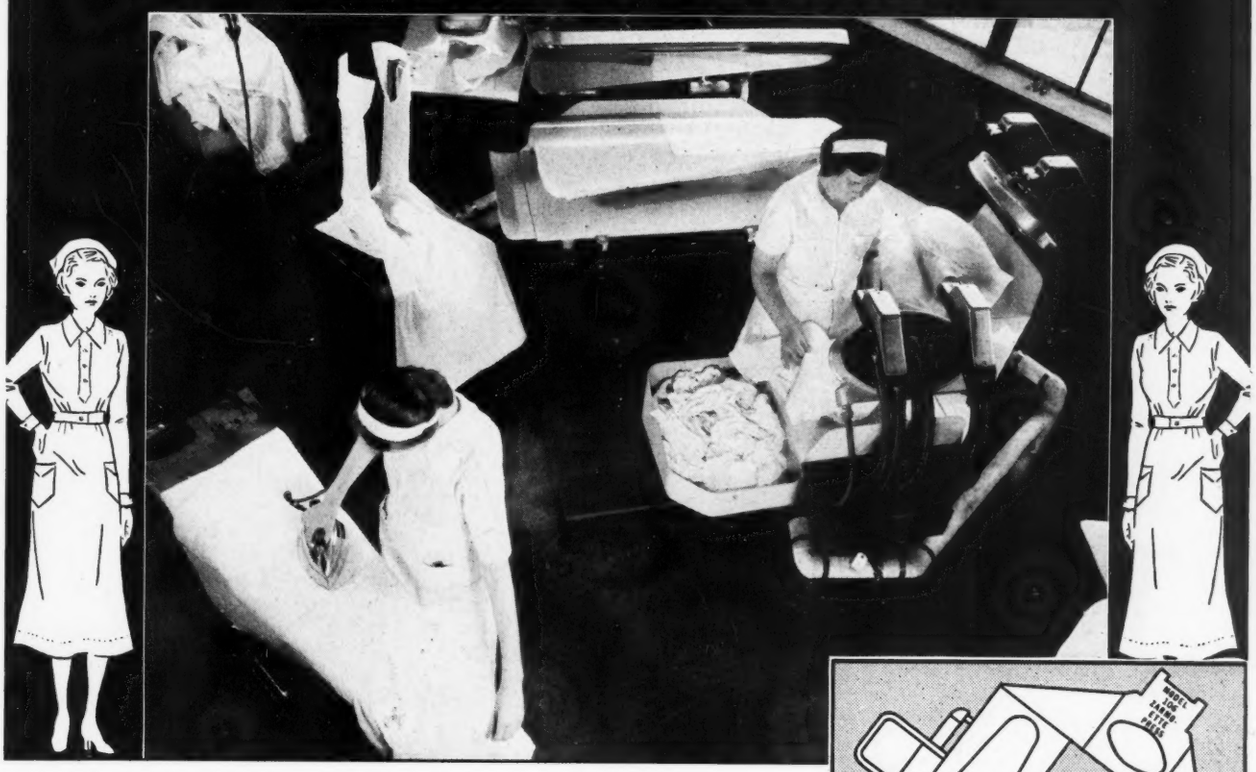

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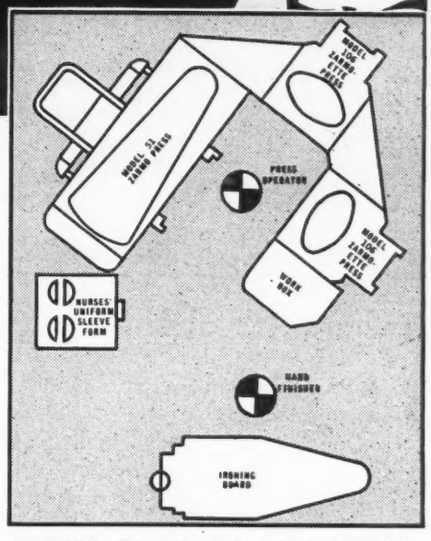
Our free laundry advisory service, available to you without obligation, will bring to light many such money-saving efficiencies. We invite you to take advantage of it. Mail the coupon for information on this helpful laundry advisory service and the high-production NURSES' UNIFORM PRESS UNIT.



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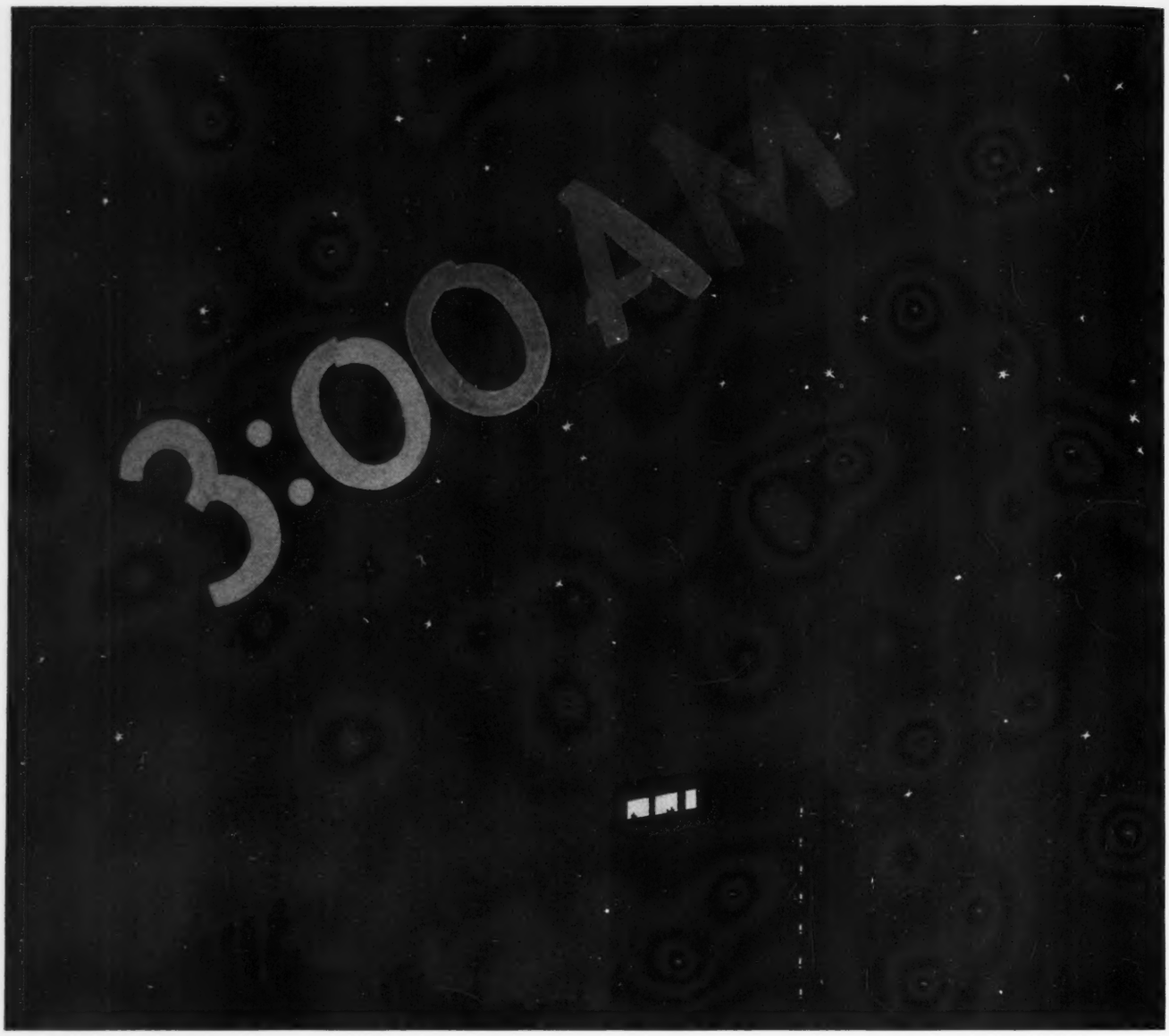

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1. Linde can furnish technical advice and assistance on operating oxygen therapy equipment.
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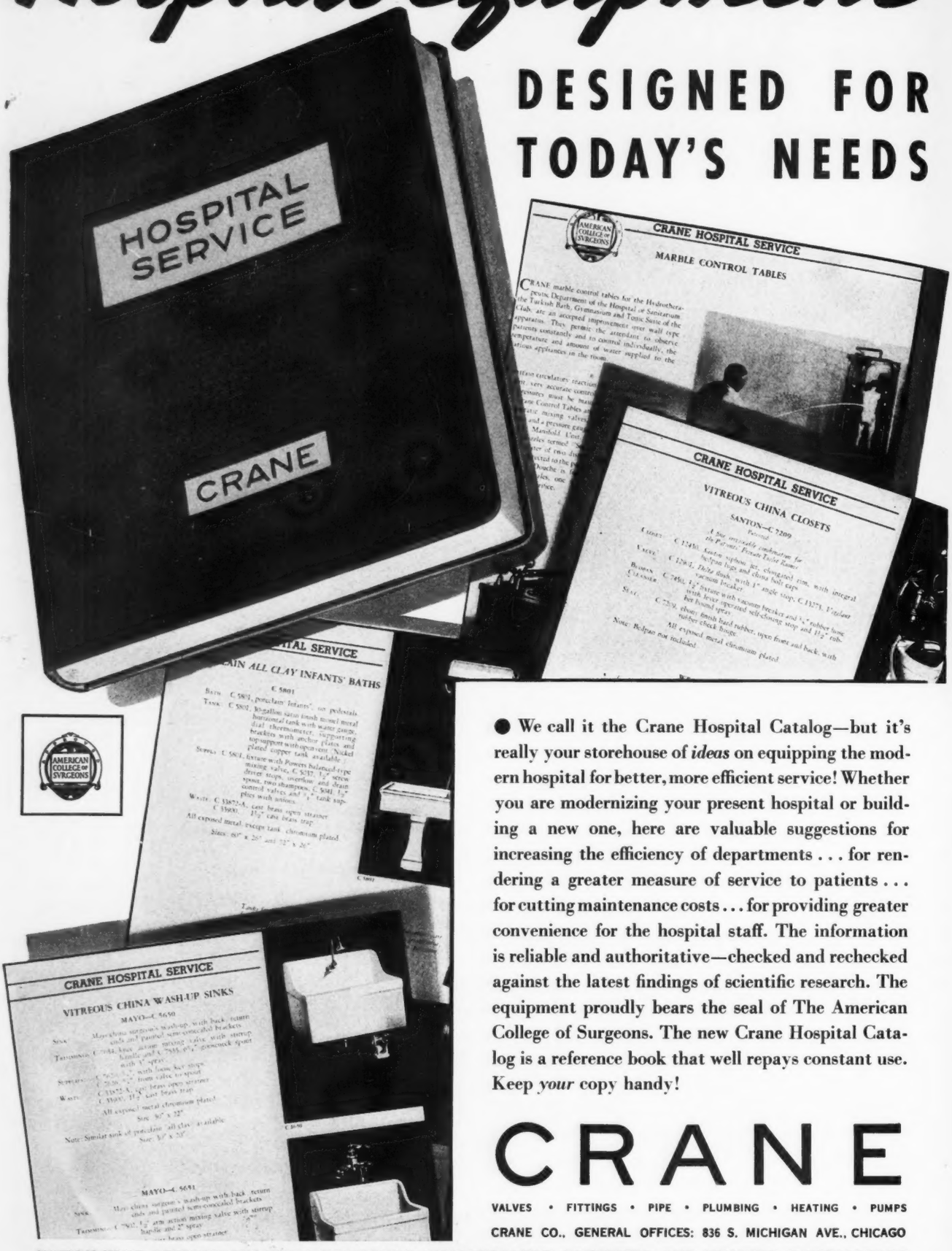

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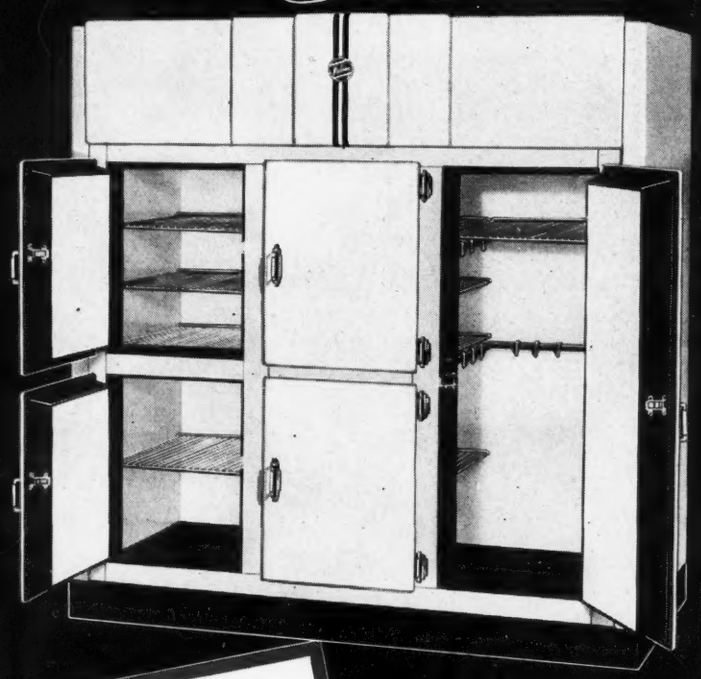
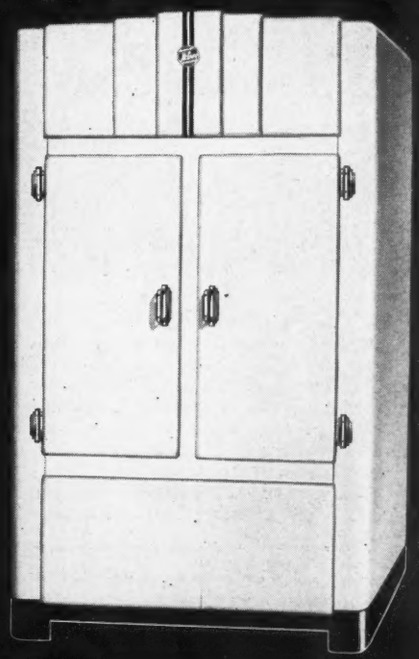


McCRAY MODEL RD-664S



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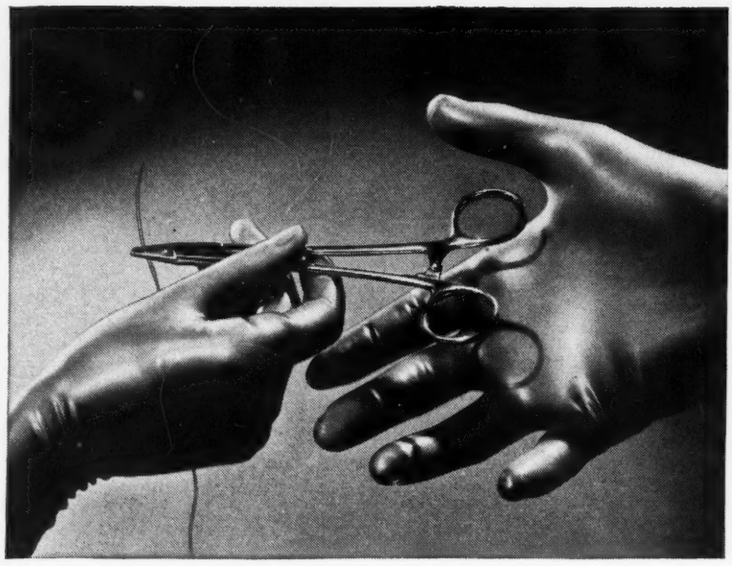

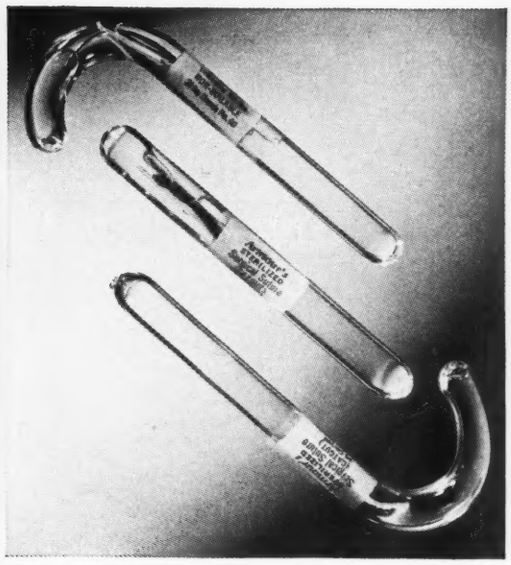

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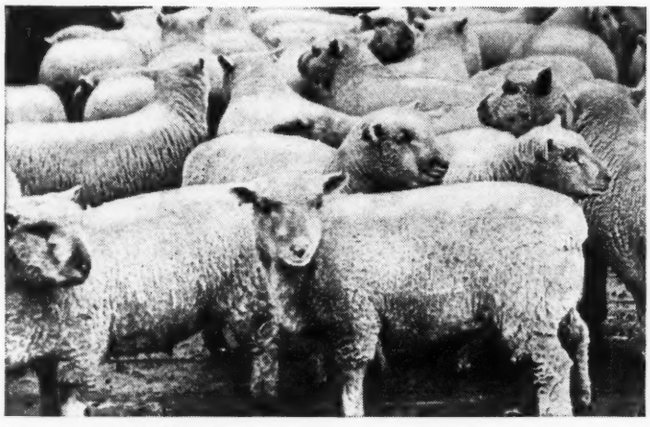

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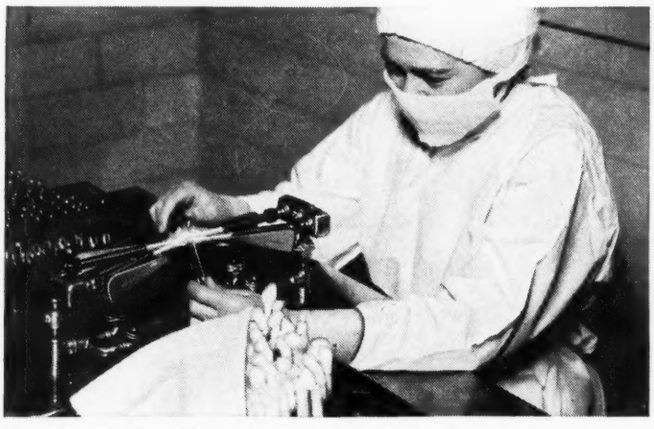

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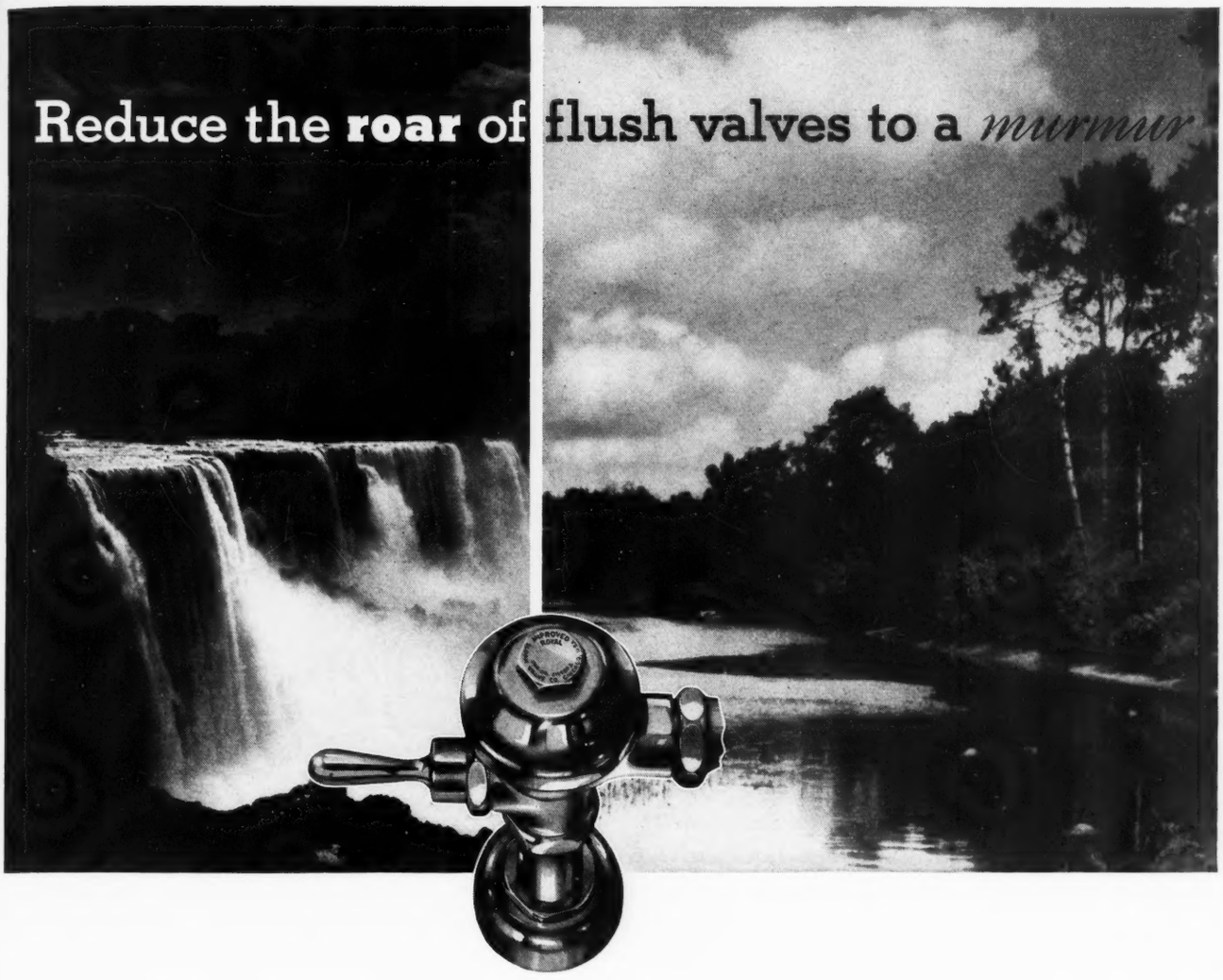


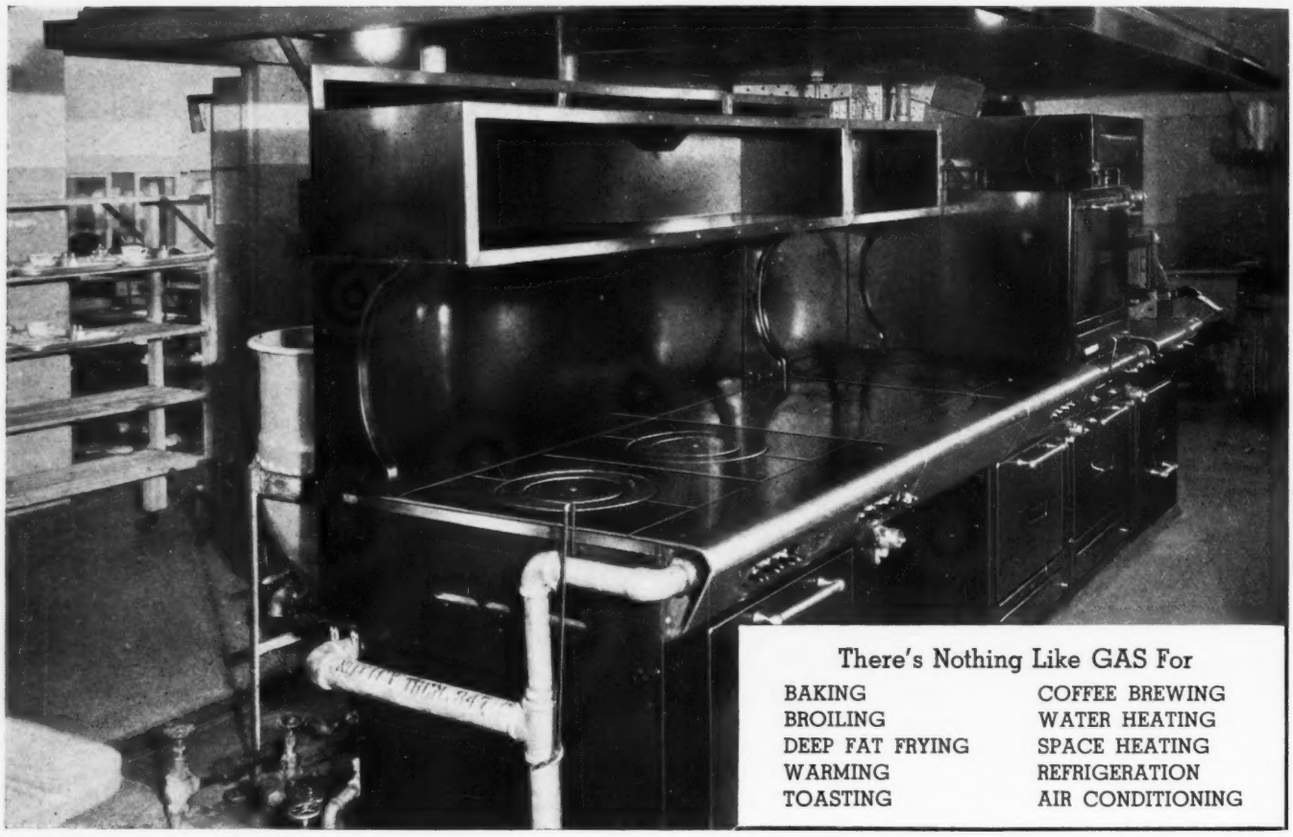
Any installation of Sloan Royal, Crown, Star or Naval Flush Valves, regardless of when installed, may now be made *completely quiet* by installing two small silencing elements. Merely replace the present stop valve; then insert a new guide and seat in the flush valve. This single inexpensive change reduces flush valve noises to the faintest whisper. • Sloan-equipped hotels—hospitals—apartments—offices—schools (every place where noise elimination is desired) are now adapting this easy, economical solution to the noise problem. • Sloan *Quiet-Flush* equipment is unlike any other silencing device. It combines the best features of generally known methods with important contributions from Sloan research. The world's most universally used flush valve now offers you the added advantage of quiet operation. Write today for descriptive folder.

SLOAN VALVE COMPANY • CHICAGO
4300 WEST LAKE STREET

SLOAN *Quiet Flush* VALVES

FREE YOUR DIETITIAN FROM ROUTINE KITCHEN WORK WITH MODERN *Gas* EQUIPMENT

Vulcan GAS Ranges, with heat-controlled ovens, ceramic broiler and roasting oven, bring important savings to Grace Hospital, New Haven, Conn.



There's Nothing Like GAS For

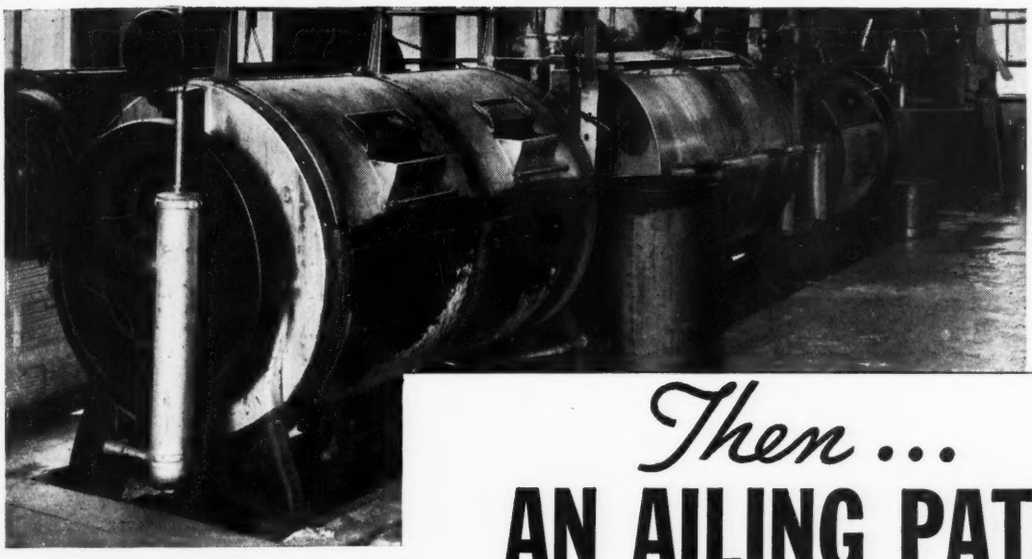
BAKING	COFFEE BREWING
BROILING	WATER HEATING
DEEP FAT FRYING	SPACE HEATING
WARMING	REFRIGERATION
TOASTING	AIR CONDITIONING

An excellent dietary service is a decided asset for any hospital. And the hospital kitchen which functions as a well-equipped food laboratory soon increases the pride of patients, the morale of personnel, and the hospital's standing as an influence in the community.

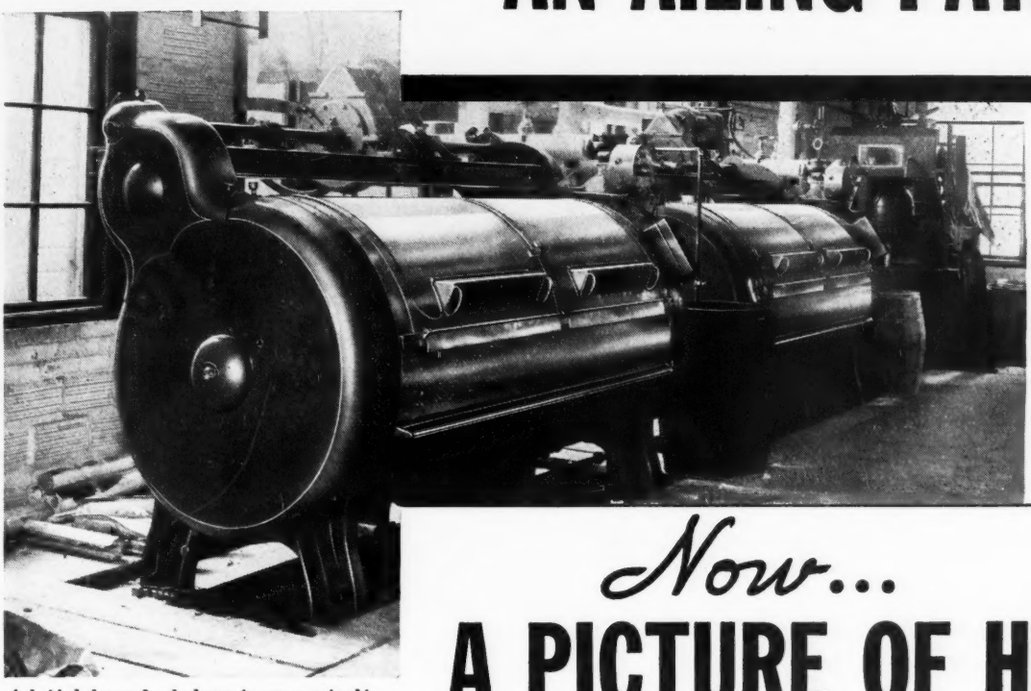
Realizing the value of freeing the dietitian from time-consuming routine in the kitchen, many hospitals today are modernizing their cooking facilities with automatically controlled GAS equipment —ranges, broilers, bake ovens and toasters that both improve the quality of food and bring appreciable savings in fuel and attendance costs.

Investigate the many advantages of GAS equipment for your kitchen!

AMERICAN GAS ASSOCIATION
INDUSTRIAL GAS SECTION
420 LEXINGTON AVENUE, NEW YORK



Then... AN AILING PATIENT



Now... A PICTURE OF HEALTH

A decided change for the better is apparent in this laundry of one of the large New England hospitals. And the Monel washers installed by U. S. Hoffman Machinery Co., Syracuse, N. Y. make a far greater difference than any you can see. Taking no more space than the old-fashioned units (top picture), they substantially increase production and cut costs.

Monel imparts to the laundry the clean and healthy vigor that assures more and better work

Does your laundry need a diagnosis? If so, look for these symptoms: Poor circulation in washers, a heavy appetite for soap and supplies, high bacteria count, and a general slowing up.

These symptoms, prevalent in most laundries equipped with old-fashioned washers, indicate the lack of an important item... Monel. Include this life-giving element, and dangerous symptoms disappear as if by magic... never to return.

Monel gives to washers a healthy, muscular body with no excess weight. Modern Monel washers are strong, durable and highly efficient. Designed to take advantage of Monel's resistance to corrosion and lasting strength, they turn out more and better work than do old-fashioned washers... and do it in less time. In addition, they show substantial savings on power, water, soap, supplies and labor.

Your patients appreciate the kind of treatment that improves their health. So does your laundry... *and it shows its appreciation in dollars and cents saved.* Write for further information on Monel. Address:

THE INTERNATIONAL NICKEL COMPANY, INC.
67 Wall Street **New York, N. Y.**

• • •

"Monel" is a registered trade-mark of the International Nickel Company, Inc., which is applied to a nickel alloy containing approximately two-thirds nickel and one-third copper.

MONEL INCO MONEL

IRON ARM

the Surgeons' Needle that is UNIFORM in TOUGHNESS, RESILIENCY and HARDNESS

To secure a surgeons' needle that was always uniform—in Toughness, Resiliency and Hardness—one where every needle used was exactly like the last in every respect, we went to England.

Here was a needle manufacturer—MILWARD'S of Redditch—who had been famous for more than 200 years. When Milward turned to the manufacture of IRON ARM Surgeons' Needles they brought to the surgical field the wealth of *two centuries* of experience of fine needle-making.

The Secret of UNIFORMITY of IRON ARM Needles

Here was an unusual combination: experience, equipment, processes and standards—the essentials required in producing absolute consistency in the quality of needles. But Milward's *scientific control* of every stage of manufacture—from the raw material to the finished product—is the true secret of UNIFORMITY in IRON ARM Needles. For when every step of the procedure is so uniform and constant the final result will be uniform.

Here are some of the controlled steps of manufacture which assure IRON ARM needle Uniformity:

Uniform Steel: The raw material that is used in IRON ARM Needles is made uniformly—to a special formula—by one of Sheffield's oldest houses. Even so it is constantly checked by chemical analysis at the Milward plant.

Special Machinery: Designed by Milward to produce absolute uniformity is used—to draw the wire, to "make" the needle.

Uniform Tempering: Tempering and hardening that insure absolute uniformity are obtained in the special electric-heating furnaces, scientifically controlled by the aid of pyrometers.

Uniform Finishing: The finish on IRON ARM Needles is uniformly applied in accordance with set standards, the result of long experience. Microscopic inspection of the "mirror finish" maintains rigid control and assures uniformity.

Uniform Control: Rigid control throughout every stage of manufacture—control of raw material; control of processes by every known scientific aid; control of the result by every modern test.

Thus it is easy to see that such uniformity of procedure and inspection—from the raw material to the finished product—would produce a needle of extraordinary UNIFORMITY. It has.

That is the Surgeons' Needle we invite you to test: IRON ARM. Check it for uniform Toughness, Resiliency and Hardness. Now available through your surgical instrument dealer in most sizes and types.

APPROVED AMERICAN COLLEGE OF SURGEONS

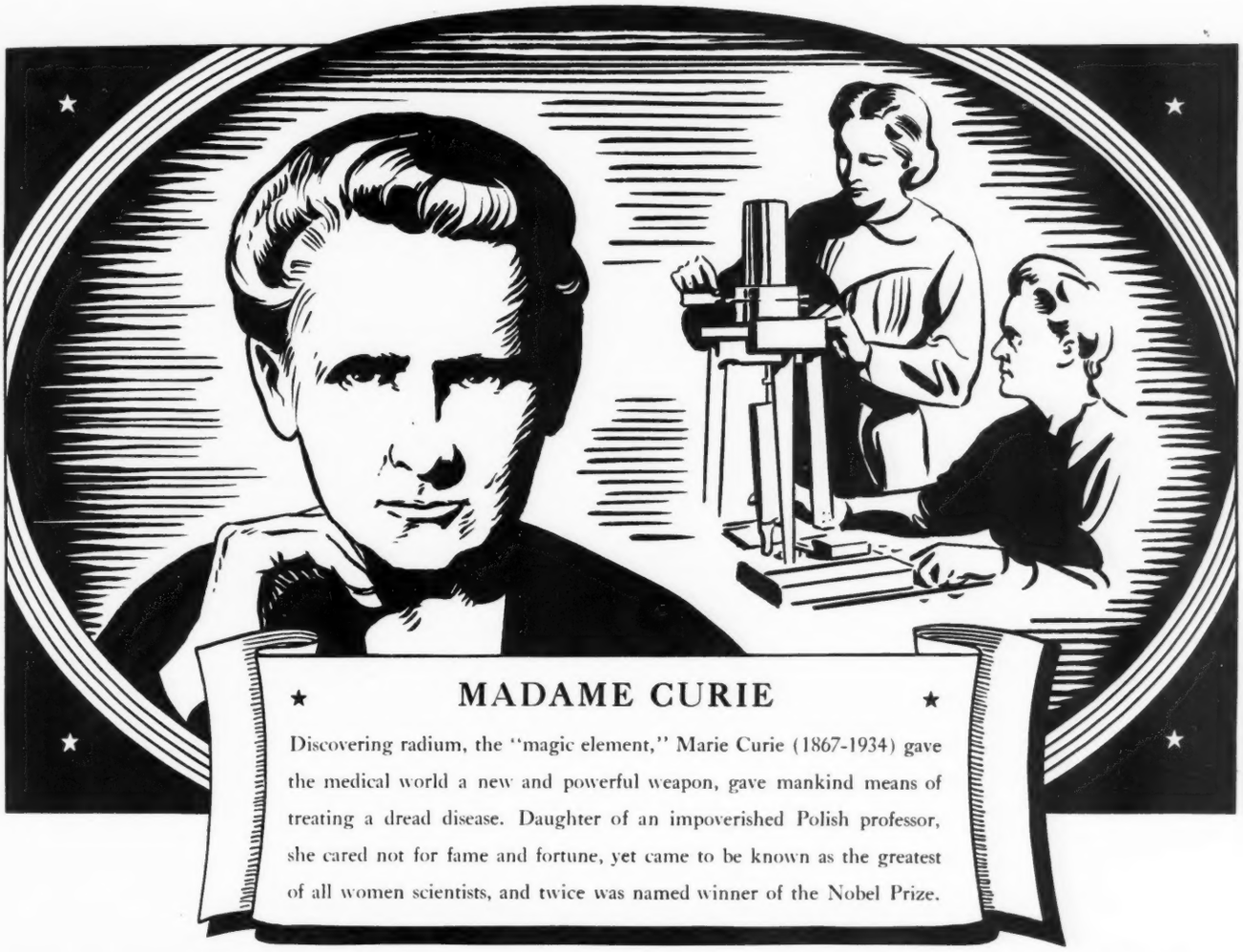
Sole Distributors in the Americas for
IRON ARM Surgeons' Needles
(Made in England)

MacGREGOR INSTRUMENT COMPANY + Needham, Mass.

Makers of VIM Hypodermic Needles and VIM Syringes

ORDER IRON ARM Needles through your regular Surgical Instrument Dealer

PIONEERS IN MEDICINE AND SURGERY • NO. 28



MADAME CURIE

Discovering radium, the "magic element," Marie Curie (1867-1934) gave the medical world a new and powerful weapon, gave mankind means of treating a dread disease. Daughter of an impoverished Polish professor, she cared not for fame and fortune, yet came to be known as the greatest of all women scientists, and twice was named winner of the Nobel Prize.

FOR BEST RESULTS IN X-RAY THERAPY

Hospitals Require Equipment Commensurate with the Broad Knowledge and Skill of the Roentgenologist

CONTINUALLY enriched in the knowledge of his profession, the roentgenologist approaches therapeutic problems with confidence. But a hindrance to the achievement of results comparable with the best reported in his field, is inadequate equipment. Antiquated equipment, inefficient equipment, can only serve to retard progress—to withhold therapeutic results far short of today's possibilities. ¶ The roentgen profession itself has decreed the requirements in equipment for modern x-ray therapy—has inspired the development and design of the new and more efficient apparatus now available. The hospital offering a high-voltage x-ray therapy service should, in justice to its roentgenologist, see that he is equipped with apparatus that fulfills present-day requirements, to further assure patients the full benefits of his knowledge and skill. ¶ Recognizing its share of responsibility, the General Electric organization has, in collaboration with the profession, developed a series of high-voltage units—the Maximar series—which merit consideration in any plans for x-ray therapy service. These famous Maximar units, used the world over, have established performance records for unusually high efficiency, reliability, and economy of operation second to none. ¶ It will pay you to investigate a Maximar installation, scientifically planned for your specific requirements by an experienced staff of layout engineers. Write and ask for their help.

GENERAL ELECTRIC X-RAY CORPORATION
2012 JACKSON BOULEVARD CHICAGO, ILLINOIS

World LEADERSHIP

A REPRODUCTION OF THE NEW GUMPERT PLANT WHERE THE 900 GUMPERT PRODUCTS ARE MADE

IN COMMERCIAL FOOD SPECIALTIES VOLUME

HOUSED in this vast 22,000-window plant is the largest, most completely equipped series of kitchens and laboratories in the commercial food specialities field. Yearly, all over the world, millions of consumers enjoy food products made from Gumpert's, and pay more than $73,000,000 for the pleasure.

50,000 restaurants, bakeries, hotels, institutions and ice cream manufacturers enjoy quality patronage — they use and serve Gumpert products.

For 46 years the Gumpert organization has been noted for leadership in volume and quality in its field, for distinguished service in originating new products and improving existing ones.

The world leadership and size of the Gumpert food organization make possible volume buying power and more efficient manufacturing and research facilities. This means right prices and insured quality, together with more helpful and dependable *service*.

It is always good business to sell the products of a leader in any line.

S. GUMPERT COMPANY, Inc. • • • Ozone Park, New York City, N. Y.

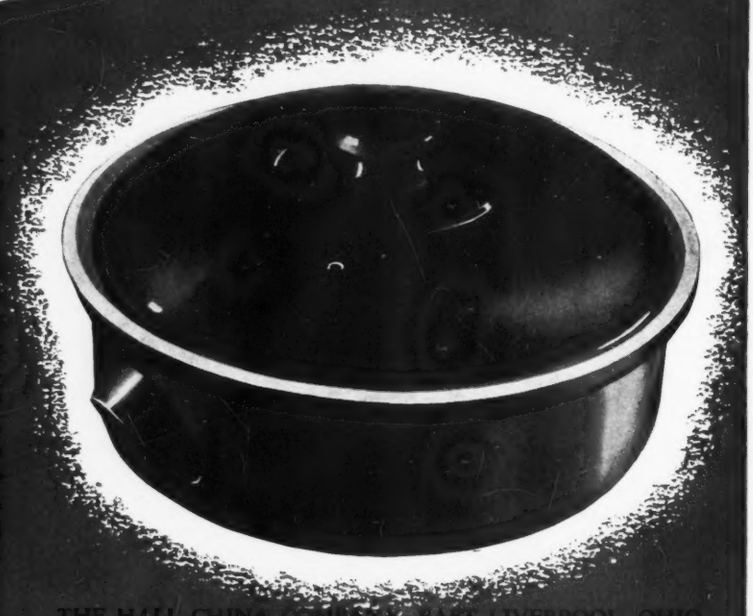
Just what the Doctor Ordered!

Casserole Cookery for Convalescents

The recipe prepared in a Hall China Casserole is delicately cooked, hot and savory, steaming and bubbling in its own wholesome juices. It's just what the doctor ordered—nourishment at its health building best.

Casserole cookery has other qualities that make it especially adaptable to the hospital bill-of-fare. The use of one dish from range to room prevents food shrinkage, saves fuel, reduces china inventory and breakage, and cuts dishwashing expense.

Hall China is perfect for casserole cookery. Its shape is designed for even distribution of heat, prevents scorching or cutting cooking, and keeps food oven-hot for protracted serving. Its glaze contains no lead, and it is the only known china that is crazeproof, fireproof, stain-proof, and absorption-free because it is made by an exclusive, secret process.



THE HALL CHINA COMPANY, EAST LIVERPOOL, OHIO

HALL FIREPROOF CHINA

Made by an exclusive secret process

COOKING · SERVING · STORAGE · ROOM EQUIPMENT